| **Gregory E. Le D.M.D** | 3320 Los Coyotes Diagonal Ste 250 Long Beach Ca 90808

DENTAL OFFICE NEW PATIENT FORM

Thank you for selecting our dental office.
To help us meet all of your health care needs, please complete this form as accurately as possible. ☺

I. PATIENT INFORMATION:

Today's Date:_______________ E-mail Address:____________________

Patient Full Name ____

Social Security # ____________________Birth Date __/___/____ Age ___

Male ( ) Female ( ) Marital Status ________________

Address: ____

City: _______________________STATE:_______ ZIP: ___________

Employer ______________________Occupation ____________________

Previous Dentist:___________ ___________Phone:___________________

Current Physician _____________________Phone: __________________

Whom may we thank for referring you? ____________________________

II. TELEPHONE:

Home Phone ___________________ Work Phone _________________

Cell Phone _______________________________

Emergency Contact:

Name __________________________Relationship _________________

Contact Phone ___________________ Work Phone _________________

III. PERSON RESPONSIBLE FOR ACCOUNT:

Name ____

Relationship _________________ Social Security # _________________

Contact Phone _____________________Date of Birth _______________

IV. INSURANCE INFORMATION:

Primary Insurance:

Subscriber Name:______________________Date of Birth _____________

Relationship to Patient:_____________ Subscriber's SSN:______________

Insurance ID#:_____________________Group ID#:_________________

Insurance Name:____

Insurance Telephone No.:________________________________

Secondary Insurance:

Subscriber Name:______________________Date of Birth ______________

Relationship to Patient:_____________ Subscriber's SSN:__________ _____

Insurance ID#:_________________________Group ID#:_______________

Insurance Name:____

Insurance Telephone No.:________________________________

V. NOTICES: Please Initial Below:

_____ I have read and understood HIPAA (Notice of Privacy Act)

_____ I assign **Gregory E. Le DMD, Inc.** all my right, title, and interest in and to any and all dental benefits otherwise payable to me for oral health Treatment rendered by the assignee. I acknowledge that billing my Insurance company for the services rendered is a courtesy done by **Gregory E. Le DMD, Inc.** I am still responsible for paying the above- referenced dentist to the extent the relevant insurer or payer does not pay the dentist in full.

_____ I was notified: Payments are expected at the time services are rendered. That if I must change my appointment I must notify **Gregory E. Le DMD, Inc.** at least 48 hours notice to avoid a $50.00 fee. *(Emergencies are an exemption).

_____ I am aware that **Gregory E. Le DMD, Inc.** offers different payment plan options.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental series that I may need during diagnosis and treatment with my informed consent.

____

Signature Date

| **Gregory E. Le D.M.D.** | 3320 Los Coyotes Diagonal Ste 250 Long Beach Ca 90808

DENTAL HISTORY:

Reason for today's visit:_______________________________________

Your current dental health is: Good Fair Poor

Do you:

Require antibiotics before dental treatment? Y N

Have pain now? Y N

Now have or experienced pain /discomfort in your jaw joint ? Y N

Clench or grind your teeth while asleep or awake? Y N

Like your smile? Y N

Have bleeding gums? Y N

Have sensitivity in any of your teeth? Y N

You have family history of gum disease or tooth loss? Y N

Have mouth odors? Y N

Do food tend to be caught between your teeth? Y N

How many times a week do you floss?_____ a day do you brush? _____

Have you ever had:

Orthodontic treatment? Y N

Oral surgery? Y N

Periodontal treatment? Y N

Your teeth ground or the bite adjusted? Y N

A bite plate or mouth guard? Y N

Headaches, neck aches or shoulder aches? Y N

A serious/ difficult problem associated with any previous dental work? Y N

If so, please describe, including cause: ____________________

____

A serious injury to the mouth or head? Y N

If so, please describe, including cause: ________________

____

Have you ever taken Phen-Fen? Y N
(also known as Redux or Pondimin)

If so, when? ____

Have you ever taken Fosamax? Y N

If so, when? ____

Is there anything else you would like for Dr.Gregory Le to know?

MEDICAL HISTORY:

Your current dental health is: Good Fair Poor

Do you smoke or use tobacco in any other form? Y N

Are you currently under a physician's care? Y N

Please explain: ____

Are you taking any prescription/ over-the-counter drugs? Y N

Please list: ____

____

For Women: Are you taking birth control pills? Y N

Are you pregnant? Y N Week#: __________

Are you nursing? Y N

Have you ever had any of the following disease or medical problems?
(Please circle all options that apply)

Y N Anemia/Radiation Treatment
Y N Artificial Bones/Joints/Valves
Y N Arthritis/Gout
Y N Asthma
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing/Sleep Apnea
Y N Drug/Alcohol Abuse
Y N Emphysema/Glaucoma
Y N Epilepsy/Seizures/Fainting Spells
Y N Fever Blisters/Herpes
Y N Heart Attack/Stroke
Y N Heart murmur
Y N Heart Surgery/Pacemaker
Y N Hemophilia/Abnormal Bleeding
Y N Hepatitis
Y N High/Low Blood Pressure
Y N HIV+/AIDS Positive
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Mitral Valve Prolapse
Y N Psychiatric Problems/Depression
Y N Severe/Frequent Headaches
Y N Shingles
Y N Gerd/GI Problems
Y N Sinus Problems
Y N Tuberculosis (TB)
Y N Ulcers/Colitis
Y N Venereal Disease
Y N Thyroid

Please list any serious medical condition(s) that you have ever had:

____

Please list any bone medications you may take:

Are you allergic to any of the following?

Y N Aspirin Y N Erythromycin Y N Penicillin Y N Codeine

Y N Jewelry/Metals Y N Tetracycline Y N Dental Anesthetics Y N Latex

Please list any other drugs/material that you are allergic to:

____