

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

Patient Information

Patient Name						
Address						
Gender	☐ Female	☐ Male	☐ Other		Birthday	
Status	☐ Married	☐ Single	☐ Partnered		☐ Minor	
Occupation	☐ Student	☐ Employed	☐ Retired	☐ Unemployed		
Name of School/Employer						
Who can we thank for referring you?						

Contact Information

Home Phone		Cell Phone		Work Phone	
Email					
Preferred Contact Method					
Emergency Contact Name		Phone			

Dental Insurance

Responsible for billing?		Relationship to Patient?	
Subscriber Name		Subscriber Date of Birth	
Insurance Company		Insurance Co Phone#	
ID or SSN#		Group Name/#	
Do you have additional dental insurance coverage? If yes, please fill out your secondary information below.			
Subscriber Name		Subscriber Date of Birth	
Insurance Company		Insurance Co Phone#	
ID or SSN#		Group Name/#	

Assignment & Release

☐ I certify that I, and/or, my dependent(s) have insurance coverage with THE ABOVE-NAMED COMPANY(IES) and assign directly to DR MICHELLE LACUES all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for services and determining insurance benefits or the benefits payable for related services. This consent will end when the above insurance(s) has/have been terminated or my status as an active patient of this office ceases.

☐ I do not have Dental Insurance. Prices and fees quoted to me are considered an estimate and may not reflect the final cost. I understand that all fees and co-pays are due at the time of service unless other payment arrangements have been agreed upon prior to my appointment.

Signature of Patient, Parent or Guardian

Dental History

Reason for today's visit

Former Dentist Date of last x-rays

Please check all conditions that apply:

- | | | |
|--|--|--|
| ☐ Bad breath | ☐ Food collection between teeth | ☐ Mouth pain, brushing |
| ☐ Bleeding gums | ☐ Foreign objects (biting things) | ☐ Orthodontic treatment |
| ☐ Blisters on lips or mouth | ☐ Grinding/clenching teeth | ☐ Pain around ear |
| ☐ Burning sensation on tongue | ☐ Gums, swollen or tender | ☐ Periodontal treatment |
| ☐ Chew on one side of mouth | ☐ Jaw pain or tiredness | ☐ Sensitivity to cold |
| ☐ Cigarette, pipe or vape smoking | ☐ Lip or cheek biting | ☐ Sensitivity to heat |
| ☐ Clicking or popping jaw | ☐ Loose teeth or broken fillings | ☐ Sensitivity to sweets |
| ☐ Dry mouth | ☐ Mouth breathing | ☐ Sensitivity to pressure |
| ☐ Fingernail biting | ☐ Mouth pain, brushing | ☐ Sores or growths in mouth |

Are you interested in whiter teeth? What kind of tooth brush do you use?

Health History

Physician's Name Date of last visit

Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, or Evista in the past 12 years?

Have you, or a family member, had any unusual or serious reactions to general anesthesia?

Have you had any major hospitalizations or surgeries in the last 5 years?

Are you pregnant or nursing?

Please check all conditions that apply:

- | | | |
|--|--|--|
| ☐ AIDS/HIV | ☐ Emphysema | ☐ Psychiatric Care |
| ☐ Anemia | ☐ Epilepsy/Seizure disorder | ☐ Radiation treatment |
| ☐ Arthritis, Rheumatism | ☐ Fainting or dizziness | ☐ Respiratory Disease |
| ☐ Artificial Heart Valve | ☐ Glaucoma | ☐ Rheumatic Fever |
| ☐ Artificial Joints | ☐ Headaches or Migraines | ☐ Scarlet Fever |
| ☐ Asthma | ☐ Heart Murmur | ☐ Shortness of breath |
| ☐ Back problems | ☐ Heart problems | ☐ Sinus trouble |
| ☐ Bleeding abnormally with extractions or surgery | ☐ Hepatitis | ☐ Skin rash |
| ☐ Blood Disease | ☐ Herpes or cold sores | ☐ Special diet |
| ☐ Cancer | ☐ High Blood Pressure | ☐ Stroke |
| ☐ Chemical Dependency | ☐ Jaundice | ☐ Swollen feet or ankles |
| ☐ Chemotherapy | ☐ Jaw pain | ☐ Swollen neck glands |
| ☐ Circulatory problems | ☐ Kidney Disease | ☐ Thyroid problems |
| ☐ Congenital Heart Lesions | ☐ Liver Disease | ☐ Tonsillitis |
| ☐ Cortisone treatments | ☐ Low Blood Pressure | ☐ Tuberculosis |
| ☐ Cough, persistent or bloody | ☐ Mitral Valve Prolapse | ☐ Tumor/growth on head/neck |
| ☐ Diabetes | ☐ Nervous problems | ☐ Venereal Disease/STD |
| | ☐ Pacemaker | ☐ Weight loss, unexplained |

Medications

Please list any medications you are currently taking and the condition they are prescribed for. Please include supplements

Allergies

Please check all that apply

- | | | | | |
|---------------------------------------|--------------------------------------|---------------------------------|---|--|
| ☐ Aspirin | ☐ Codeine | ☐ Iodine | ☐ Local Anesthesia | ☐ Sulfa |
| ☐ Barbiturates | ☐ Epinephrine | ☐ Latex | ☐ Penicillin | ☐ Other: <input type="text"/> |