Louisiana Dental Center
FAMILY DENTISTRY AND SPECIALTY PRACTICE

PATIENT INFORMATION

Name: _____ Date: _____
Last First MI

Address: _____
Street Apt/Ste City State Zip Code

Telephone: Hm _____ Wk _____ Cell _____ Gender (Circle): M / F State DL/ID #: _____

Date of birth: _____ SS #: _____ Email Address: _____ Status: Married __ Single __ Child __

If patient is a minor, Parent/Guardian Name: _____ Relationship to Patient: _____

Insurance Policy Holder's Name: _____ SS#: _____ Date of birth: _____

Insurance Co.: _____ Group #: _____ Employer Name/Phone #: _____

Emergency Contact Name/Relationship/Phone #: _____

MEDICAL HISTORY

Do you have or have you ever had any of the following?

AIDS/HIV	Yes No	Diabetes	Yes No	High Blood Pressure	Yes No
Anemia	Yes No	Dizziness	Yes No	Kidney Disease	Yes No
Angina	Yes No	Epilepsy	Yes No	Leukemia	Yes No
Arthritis	Yes No	Excessive Bleeding	Yes No	Liver Disease	Yes No
Artificial Joints	Yes No	Fainting or Seizures	Yes No	Mitral Valve Prolapse	Yes No
Asthma	Yes No	Glaucoma	Yes No	RadiationTreatment	Yes No
Blood Disease	Yes No	Heart Attack	Yes No	Rheumatic Fever	Yes No
Cancer	Yes No	Heart Disease	Yes No	Sinus Problems	Yes No
Cardiac Pacemaker	Yes No	Heart Murmur	Yes No	Stroke	Yes No
Chest Pain	Yes No	Hepatitis	Yes No	Tuberculosis	Yes No

List any other medical condition you feel the doctor should be aware of : _____

Please list any allergies you are aware of : _____

Have you ever had an allergic reaction to: Latex Local Anesthetics Sedatives Penicillin Codeine Aspirin Sulfa Drugs Other _____

List any medications you are currently taking: _____

If female, are you pregnant? Yes No If yes, when is your due date? : _____ Do you smoke or use tobacco products: Yes No

Have you ever had any complications following dental treatment? : Yes No
If yes, please explain: _____

Have you been admitted to the hospital or needed emergency care during the past two years? : Yes No
If yes, please explain: _____

Are you under the care of a physician? : Yes No If yes, name/phone # of physician: _____

To the best of my knowledge, all of the preceding answers and information are true and correct. I understand that providing incorrect or incomplete information can be dangerous to the health of the patient. If there are any changes in health, I will inform the dental clinic staff and doctors at the earliest opportunity.

Signature of patient, parent or guardian _____ Date _____

ACKNOWLEDGEMENT AND CONSENT

1. The undersigned hereby authorizes the doctor or his/her designee to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I authorize the doctor and/or hygienist to perform all recommended treatment mutually agreed upon by me and to use appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. I authorize and consent that the doctor and/or hygienist choose and employ such assistance as deemed fit to provide recommended treatment.
2. I understand that all responsibility for payment for services provided in this office for myself or my dependents is mine, payable and due at the time services are rendered unless other arrangements have been made.
3. I understand that it is my responsibility to advise the appropriate office staff of any changes in the information contained on this form.
4. I certify that I have read and understand all of the information above and that, to the best of my knowledge, all of the information provided by me is accurate and correct.

Patient Name (Print): _____ **Date:** _____

Signature of Patient, Parent or Guardian: _____ **Relationship to Patient:** _____