LARRY J. LAVELETT, D.D.S.

GET ACQUAINTED QUESTIONNAIRE

Date _____

Name of Patient _____ Date of Birth _____ Age _____ M ____ F___

Address _____ City _____ State _____ Zip _____

Phone _____ Cell Phone _____ Email Address _____

Occupation _____ Employer _____ Work Phone _____

Social Security Number _____ Marital Status S ___ M ___ D ____ W ___

Person Financially Responsible _____ Relation to Patient _____

In case of emergency, please notify: _____

Former Dentist _____

Last Visit _____

Who may we thank for referring you?

FOR PATIENTS WITH DENTAL INSURANCE: _____

Dental Insurance Carrier _____

Policy Holder _____

Group Holder _____

*Most dental insurance plans do not cover 100% of the cost of your treatment. Because of this and because of the extreme delay in receiving payment from insurance companies, you will be asked to pay a percentage of the charges when services are rendered.

What prompted you to seek dental care at this time? _____

How often do you have your teeth examined? _____ Cleaned? _____ X-Rayed? _____

Have you experienced any discomfort from your teeth or gums lately? _____

If so, where? _____

Has the fear of discomfort kept you from regular dental visits? _____

How do feel about the appearance of your teeth? _____

Would you be interested in knowing more about cosmetic dentistry? _____

For Office Use:

PATIENT HEALTH RECORD

Physician _____ Approximate date of last physical exam _____

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

	YES	NO		YES	NO
Heart Disease	❑	❑	High Blood Pressure	❑	❑
Rheumatic Fever	❑	❑	Ulcers	❑	❑
Tuberculosis	❑	❑	Diabetes	❑	❑
Glaucoma	❑	❑	Epilepsy	❑	❑
Heart Murmer	❑	❑	Anemia	❑	❑
Hepatitis	❑	❑	Tumors or Growths	❑	❑
Kidney Disease	❑	❑	Prolonged Bleeding	❑	❑
Chest Pains	❑	❑	Fainting Spells	❑	❑
Sinus Trouble	❑	❑	AIDS or ARC	❑	❑
Pacemaker	❑	❑	Artificial Joint Replacement	❑	❑

YES	NO	
❑	❑	Are you now being treated by a physician or any health care professional?
		If so, please explain _____
❑	❑	Have you ever had an operation that required an overnight hospital stay?
❑	❑	Have you ever had a serious accident of any kind?
❑	❑	Are you allergic, or have you had an unusual reaction to any drug?
❑	❑	Have you ever had an adverse reaction to Novacaine, Penicillin, or Latex?
❑	❑	Are you now taking any drugs or medications? If so, what and how much?
		a)_____ b)_____ c)_____ d)_____
❑	❑	Do your gums bleed easily, feel tender or irritated?
❑	❑	Are your teeth sensitive to: Hot_____, Cold _____, Sweets _____?
❑	❑	Are you taking or have you ever taken Bisphosphonates for osteoporosis or cancer (Fosamax, Xctonel, Boniva, Aredia, Zometa)?
❑	❑	Are you aware of grinding or clenching of your teeth?
❑	❑	Do you have popping or clicking noises when you chew?
❑	❑	Do you have headaches, earaches or jawaches?
❑	❑	Do you wish to talk to the Doctor privately about anything?

FOR WOMEN ONLY:

❑	❑	Are you pregnant, or **is there any chance** you might be pregnant?
		If so, what is your due date _____
❑	❑	Are you nursing?

If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

Signature of Patient (Guardian)_____ Date _____

FOR DOCTORS USE

Changes in Health_____ Date _____