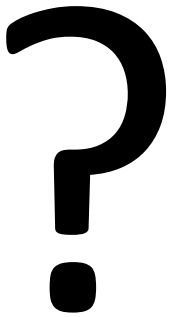
We will have more time together if you complete this form ahead of time and bring it with you to your first appointment. Thank You!

Leslie Ann Bouvier DMD
CONTEMPORARY DENTISTRY

Tell us about YOURSELF ….



Full Name _____
Address_____
City_____ State_____ Zip_____
Date of Birth_____ S.S. # _____
Employer_____ Your Occupation_____
Phone #'s: Home_____ Cell_____
Work _____ Email _____
Whom may we thank for referring you? _____

Please describe your dental health…

What is your primary goal or concern? _____
Do you like the appearance of your teeth or smile? _____
Circle any of the following that have recently caused sensitivity to your teeth:
COLD HEAT SWEETS TOUCH CHEWING PRESSURE SPONTANEOUS
Do you clench or grind your teeth, or think you might? _____
Do you wear or have you ever been recommended to wear a night guard? _____
Have you ever had any jaw or TMJ pain? YES NO Please describe _____
Is your mouth continually dry? YES NO
Do your gums bleed when you brush or floss? _____
Have you ever seen a gum specialist (periodontist) or had "deep cleanings" or quadrant scalings? _____
How often did you go to the dentist for cleanings? _____
When was your last visit the dentist? _____ For what service? _____
Have you ever bleached/whitened your teeth? _____ With which product? _____
Have you noticed any loose teeth/crowns or bridges? _____ In what area of your mouth? _____
Would you guess that you need a: minimal moderate or major amount of treatment now?
Have you ever had braces/retainers or Invisalign aligners? _____
Have you ever had a reaction to dental anesthetics? YES NO Please Describe_____
Have you ever needed to be medicated with antibiotics before dental treatment? _____
How have your past dental experiences been? _____
Please describe any other dental information that you think might be important for us to know: _____
_____

About your diet and dental home care.....

Do you drink coffee, tea or soda? Yes No If yes, how much per day? _____
Do you chew gum? Yes No Chew ice or hard candy? Yes No
Do you or have you used any form of tobacco? Yes No
What form and how long? _____
Do you think you have a high sugar diet? Yes No
How many times a day do you brush? _____ Circle the type of toothbrush you use: ELECTRIC MANUAL
Please circle how often you floss: DAILY WEEKLY RARELY NEVER

Your medical information….

Physician's Name _____ Specialty _____

Street_____ City/State _____

Are you being treated by a physician now? _____ For what reason(s)? _____

Are you taking any medications at the present time? YES NO For what reason? _____

_____

List all medications you are currently taking: _____

Are you sensitive to any drugs or medications? YES NO Please list: _____

Are you sensitive or allergic to Latex? _____ Metals? _____

Have you ever taken Fosamax? _____ When? _____ For how long? _____

Do you take aspirin regularly? Yes No Have you taken or do you take blood thinners? Yes No

Have you ever been hospitalized? YES NO List reason and dates: _____

_____

Health questions… Have you ever had?

Asthma	Yes	No
Allergies or Hives	Yes	No
Hepatitis/Liver Disease	Yes	No
Stroke	Yes	No
High Blood Pressure	Yes	No
Chemical Dependency	Yes	No
Angina Pectoris	Yes	No
Mitral Valve Prolapse	Yes	No
Abnormal Bleeding	Yes	No
Chemo or Radiation Treatment	Yes	No
Diabetes	Yes	No
Arthritis	Yes	No
AIDS or HIV infection	Yes	No
Heart Disease	Yes	No
Blood Disease/Anemia	Yes	No

Joint Replacement	Yes	No
Stomach/Intestinal Ulcers or Disease	Yes	No
Epilepsy or Seizures	Yes	No
Allergies or Hives	Yes	No
Tuberculosis	Yes	No
Pacemaker or Artificial Heart Valves	Yes	No
Heart Murmur	Yes	No
Kidney or Bladder Disease	Yes	No
Fainting or Dizzy Spells	Yes	No
Cancer	Yes	No
Respiratory Disease	Yes	No
Venereal Disease/Herpes	Yes	No
Circulatory Problems	Yes	No
Congenital Heart Disease	Yes	No
Women: Are you pregnant?	Yes	No

In case or emergency, contact…

Full Name _____ Relationship_____ Home Phone_____

Address _____ Work Phone _____ Cell _____

Do you have dental insurance?

Who is responsible for this account? _____

Relationship to patient _____

Insurance subscriber's name _____

Relationship to insured _____ S.S/ID # _____

Employer _____ Policy/Group # _____

Insurance Co._____ Insured's DOB? _____

Are you covered by any other dental insurance? _____

My signature acknowledges that:

The questions have been answered truthfully and completely,
I understand the office policy with keeping appointments,
I have received a copy of the Notice of Privacy Practices, and
I understand and will comply with the office Financial Policy.

_____ _____

Patient's signature (or Parent if minor) Date