

# *Smiles..... the ultimate accessory*

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## **HELP US TO GET TO KNOW YOU BETTER! CONFIDENTIAL PERSONAL INFORMATION**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ SS# \_\_\_\_\_

Drivers Lic. # \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Telephone: Home: \_\_\_\_\_ Business: \_\_\_\_\_

Cell: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Spouse Name: \_\_\_\_\_

Employer: \_\_\_\_\_ Referred By: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

If you are completing this form for another person, what is your relationship to this person?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

## **PERSON RESPONSIBLE FOR ACCOUNT**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Telephone: Home: \_\_\_\_\_ Business \_\_\_\_\_

## **DENTAL INSURANCE INFORMATION**

Insurance Company: \_\_\_\_\_

Address City/ State/ Zip

Employee: \_\_\_\_\_ Relationship: \_\_\_\_\_ SS#: \_\_\_\_\_

Employer: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_

**I UNDERSTAND THAT PAYMENT IS MY OBLIGATION REGARDLESS OF INSURANCE OR ANY OTHER THIRD PARTY INVOLVEMENT.  
I AGREE TO PAY 1.5% FINANCE CHARGE PER MONTH ON ANY OOUTSTANDING AMOUNTS OVER 60 DAYS.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# MEDICAL AND HEALTH INFORMATION

Personal Physician: \_\_\_\_\_  
Name Address

YES NO

- 1. Have you been hospitalized within the past 2 years? For what? \_\_\_\_\_
- 2. Are you currently being treated by a physician? For what? \_\_\_\_\_
- 3. Are you currently taking any medicines or drugs? What? \_\_\_\_\_
- 4. Have you ever received counseling for excessive use of alcohol and/or drugs? \_\_\_\_\_
- 5. Have you ever had a skin rash or other reaction to metal jewelry? To what? \_\_\_\_\_
- 6. Do you bleed excessively upon injury?
- 7. Are you pregnant?
- 8. Are you taking birth control pills?
- 9. Do you have any artificial joints? (ie. knee, hip, etc.)
- 10. Rate your health (please circle) Excellent Good Fair Poor

## ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? (please circle)

- Aspirin/Advil/Tylenol
- Iodine
- Sedatives
- Latex
- Penicillin or other antibiotics
- Sulpha drugs
- Local anesthetic
- Any metals (Gold, Silver, Mercury, Nickel, etc..)
- Codeine or other narcotics
- Other \_\_\_\_\_

Please circle if being treated for or have been treated for any of the following:

- Kidney Disease
- Heart Trouble/Attack
- Fever Blisters
- Liver Disease
- Stomach Problems
- Congenital Heart Disease
- High Blood Pressure
- History of Bulimia or Anorexia
- Frequently Tired
- Respiratory Problems
- Currently/Have Taken Fen/Phen, Redux &/or Pondium
- Asthma/Hayfever/Allergies \_\_\_\_\_
- Herpes\*Other \_\_\_\_\_
- Diabetes
- Leukemia
- Tuberculosis
- Fainting/Seizures
- Stomach Ulcers
- Stroke
- AIDS/HIV
- Heart Murmur
- Tumors/Growths
- Blood Disorders
- Mitral Valve Prolapse
- Recent Weight Loss
- Venereal Disease
- Radiation Therapy
- Rheumatic Fever
- Blood Clots
- Glaucoma
- Lung Disorders
- Swollen Ankles
- Thyroid Problem
- Cardiovascular Disease
- Drug/Alcohol Dependency
- Joint Replacement
- Hepatitis
- Canker Sore
- Artificial Heart

## DENTAL INFORMATION

Yes No Don't Know

- Do you feel you may have bad breath at times?
- Do your gums bleed when you brush?
- Are your teeth sensitive to cold, hot, sweets or pressure?
- Have you had any periodontal (gum) treatments?
- Do you occasionally have an unpleasant taste in your mouth?
- Have you ever had orthodontic (braces) treatment?
- Do you have headaches, earaches or neck pains?
- Do you wear removable dental appliances?
- Have you had a serious/difficult problem associated with any previous dental treatment? If so, explain: \_\_\_\_\_

Signature: X

Reviewed by:

Date:

Update: \_\_\_\_\_

Update: \_\_\_\_\_