LOS FRESNOS
DENTAL CENTER
Dr. Adam Lalonde

Patient Registration Date:_____/_____/_____

Last Name _____ First _____ Middle Initial_____Sex: M / F

Home Phone _____ - _____ - _____ Cell _____ - _____ - _____ Work _____ - _____ - _____

D.O.B _____/_____/_____ Age _____ Single / Married / Widowed / Child

Mailing Address_____City _____ State _____ ZIP_____

Street Address _____ City _____ State_____ ZIP_____

Employer _____ Occupation _____ SS# _____ - _____ - _____

Who is Responsible for this Account? _____ Relation to Patient _____

Dental Insurance Carrier _____ Group Number_____

Spouse/ Parent Information:

Name_____ D.O.B ___/___/_____ Relation to Patient_____

Employer _____ Occupation _____ Cell Phone _____ - _____ - _____

Medical History

Physician's Name _____ Date of Last Physical____/____/_____

Have you ever been diagnosed or experienced any of the following? (Check all that apply)

☐ADHD	☐Chemical Dependency	☐Headaches	☐Pacemaker	☐Swollen Glands
☐Arthritis	☐Circulatory Problems	☐Hepatitis/ Liver Disease	☐Radiation Treatment	☐Thyroid Problems
☐Artificial Heart Valve	☐Diabetes	☐Hemophilia	☐Rapid Weight Loss	☐Tobacco Use
☐Artificial Joints	☐Epilepsy	☐Immune Disorders	☐Respiratory Disease	☐Ulcer
☐Asthma	☐Fainting Spells	☐Kidney Problems	☐Rheumatic Fever	
☐Back Problems	☐General Allergies	☐Low Blood Pressure	☐Sinus Problems	
☐Blood Diseases	☐Heart Problems	☐Nervous System Disorders	☐Skull Injury	
☐Cancer/ Tumors	☐High Blood Pressure	☐Psychiatric Care	☐Stroke	

Are you allergic to LATEX or DENTAL ANESTHETICS? _____

Are you taking any medications? Yes / No: If so, what? _____

_____

(Women) Do you know or suspect you are pregnant? Yes / No : Approximate Due Date: _____ /_____ /_____

Have you ever responded negatively to Medical or Dental treatment? Yes / No, _____

Are you currently under the care of a physician? Yes / No : Why? _____

Is there anything else we should know about your medical history? _____

The above information is accurate and complete to the best of my knowledge. I will not hold Los Fresnos Dental Center, its owner, or its staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: :_____ /_____ /_____ **Signature**_____

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Please indicate if you were referred by any of the following (check all that apply):

☐ Video Billboard-Digital Sign ☐ LF Newspaper ☐ Building/Location ☐ Word of Mouth

☐ Internet: Website-Facebook ☐ Marketing/Advertising in Community

☐ Patient: _____ ☐ Other: _____

Email Address (for future communications with you): _____

Our goal is to exceed your expectations in a dental office; please help us get to know you better:

Why did you leave your previous dentist? _____

_____

What is the most important quality you think a dentist should have? _____

_____

With whom do you give LFDC permission to discuss your dental care? __ No one else __ Any family member

___ My spouse, name: _____ ___ Other: _____

Signed (Patient or Guardian): _____ Date: _____