Nancy Pemberton, D.D.S.
Your Healthy Smile is our Quest
111 Monsanto Avenue
Luling, LA 70070
(985) 785-0620

Patient Information:

Patient is: ☐ Responsible Party ☐ Child ☐ Policy Holder ☐ Self		**Referred by:**
Name (Last, First, MI):		**Nickname:**
SS#:	**Birth Date:**	**Drivers License #:**
☐ Male ☐ Female	**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed	
Address:		**City, State, Zip:**
Home #:( ) -	**Work #:**( ) -	**Cell #:**( ) -
Emergency Contact Name:		**Phone #:**( ) -

Fill out for Children only:

When was your first dentist visit?	Do they suck thumb/fingers?
Has it been suggested space be maintained?	Any other oral habits?
Have they had an unfavorable dental experience?	Have teeth had any injuries (chip, falls, etc.)? Explain:
Do you know if they had cavities?	Have any teeth been extracted?

Responsible Party (If someone other than patient):

Relationship to patient: ☐ Parent ☐ Guardian ☐ Spouse ☐ Other, explain:		
Name (Last, First, MI):		Suffix:
SS#:	**Birth Date:**	**Drivers License #:**
☐ Male ☐ Female	**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed	
Address:		**City, State, Zip:**
Home #:( ) -	**Work #:**( ) -	**Cell #:**( ) -

How would you like us to confirm your appointments? *Check all that apply*

☐ phone calls ☐ Text messages:( ) - ☐ emails: @

Primary Insurance:

Policy Holder:		**Relationship to Pt:** ☐ self ☐ spouse ☐ child
Birth Date:	**SS#:**	**Employer:**
Dental Ins Company:		**Ins Provider #:**( ) -
Dental Insurance Address:		
Member ID:	**Group Name:**	**Group #:**

Secondary Insurance:

Policy Holder:		**Relationship to Pt:** ☐ self ☐ spouse ☐ child
Birth Date:	**SS#:**	**Employer:**
Dental Ins Company:		**Ins Provider #:**( ) -
Dental Insurance Address:		
Member ID:	**Group Name:**	**Group #:**

Medical & Dental History:

Although dentists primarily treat the area in and around your mouth, your mouth is a part of your entire body. It is important that we know all health problems or medications you are on, this may affect the way your treatment is completed.

Physician's Name:	**Contact #:**( ) -

Please list any medication you currently take:

Do you use tobacco?	☐ no ☐ yes	**Are you taking bisphosphonates?**	☐ no ☐ yes
Are you on blood thinners?	☐ no ☐ yes	**Do you use controlled substances?**	☐ no ☐ yes

Allergies:

Are you allergic to anything? ☐ no ☐ yes, please answer next question

What are you allergic to? ☐ Acrylic ☐ Aspirin ☐ Codeine ☐ Latex ☐ Metal ☐ Local Anesthetics ☐ Penicillin ☐ Sulfur ☐ Other, please explain:

Have you ever had any of the following?

AIDS/HIV	☐ no ☐ yes	Frequent Headaches	☐ no ☐ yes
Alzheimer's disease	☐ no ☐ yes	Glaucoma	☐ no ☐ yes
Anemia	☐ no ☐ yes	Heart Attach/Failure	☐ no ☐ yes
Angina	☐ no ☐ yes	Heart Murmur	☐ no ☐ yes
Artificial Heart Valve	☐ no ☐ yes	Hepatitis	☐ no ☐ yes
Artificial Joint	☐ no ☐ yes	High Blood Pressure	☐ no ☐ yes
Asthma	☐ no ☐ yes	Irregular Heartbeat	☐ no ☐ yes
Blood Transfusion	☐ no ☐ yes	Jaw Joint Pain	☐ no ☐ yes
Bruise Easily	☐ no ☐ yes	Kidney Problems	☐ no ☐ yes
Cancer	☐ no ☐ yes	Liver Disease	☐ no ☐ yes
Chemotherapy	☐ no ☐ yes	Mitral Valve Prolapse	☐ no ☐ yes
Congenital Heart Disorder	☐ no ☐ yes	Radiation Treatment	☐ no ☐ yes
Cortisone Medicine	☐ no ☐ yes	Rheumatic Fever	☐ no ☐ yes
Diabetes	☐ no ☐ yes	Sinus Trouble	☐ no ☐ yes
Drug Addiction	☐ no ☐ yes	Stroke	☐ no ☐ yes
Emphysema	☐ no ☐ yes	Thyroid Disease	☐ no ☐ yes
Epilepsy/Seizures	☐ no ☐ yes	Ulcers	☐ no ☐ yes
Fever Blisters	☐ no ☐ yes	Other, not listed:	

Women only *answer the following*:

Are you pregnant? ☐ no ☐ yes	**Are you Nursing?** ☐ no ☐ yes	**Are you on Birth Control?** ☐ no ☐ yes

What is the reason for today's visit?	**When were your last x-rays taken?**
Where & when was your last dentist visit?	
Any serious complications associated with previous dental treatment?	
Were there any complications linked with previous treatment?	
Do your gums bleed or feel tender?	**Do you have sensitivity to hot/cold, sweets, pressure?**

What are your concerns? *Circle all that apply* Pain Avoidance • Appearance • Losing Teeth • Gum Disease • Cavities • Oral Cancer • Exceeding Insurance Limits • General Health • Routine Cleaning • Other:

INFORMED CONSENT – The undersigned hereby authorizes the doctor to perform all the necessary diagnostic procedures deemed appropriate to make a thorough diagnosis of the patient's dental or oral-facial needs including x-rays, study models, photographs, medications, and use of local anesthetic agents. I have read and understand the office policy (H.I.P.P.A.).

PATIENT/PARENT/GUARDIAN SIGNATURE:_____ **DATE:**_____