



Ken S. LeBlanc, DDS, PC
Cosmetic, Restorative and General Dentistry

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Patient Registration

First Name: Last Name: Preferred Name:
How did you hear about us?:
Address: Address 2:
City: State/Zip: Cellular:
Home Phone: Work Phone: Ext:
Sex: [] Male [] Female Marital Status: [] Married [] Single [] Divorced [] Separated [] Widowed
Birth Date: Age: Soc. Sec.: Drivers Lic.:
E-Mail: I would like to receive correspondences via [] E-mail [] Text
Employment Status: [] Full Time [] Part Time [] Retired Place of Employment:
Employee ID: Preferred Pharmacy:

Responsible Party (if someone other than the patient)

First Name: Last Name:
Address: Address 2:
City: State/Zip: Pager:
Home Phone: Work Phone: Ext: Cellular:
Birth Date: Soc. Sec.: Drivers Lic.:

Primary Insurance Information

Name of Insured: Relationship to Insured: Self Spouse Child Other
Insured Soc. Sec.: Insured Member ID: Insured Birth Date:
Employer: Ins. Company:
Address: Address:
Address 2: Address 2:
City, State, Zip: City, State, Zip:

Secondary Insurance Information

Name of Insured: Relationship to Insured: Self Spouse Child Other
Insured Soc. Sec.: Insured Member ID: Insured Birth Date:
Employer: Ins. Company:
Address: Address:
Address 2: Address 2:
City, State, Zip: City, State, Zip:

Dental History

How long since your last dental visit? _____ Former dentist and city? _____

How long since your last complete dental examination (including complete dental x-ray series)? _____

How long since your teeth have been cleaned professionally? _____

How often do you usually have your teeth cleaned professionally? _____

Any history of:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Sensitive areas in your mouth | <input type="checkbox"/> Pain or ringing in the ears | <input type="checkbox"/> Endodontic (root canal) treatment |
| <input type="checkbox"/> Tender or Swollen Gums | <input type="checkbox"/> Rough, irregular or bothersome areas | <input type="checkbox"/> Headaches | <input type="checkbox"/> Crown (cap) or bridges |
| <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Food collecting between teeth | <input type="checkbox"/> Tired jaws | <input type="checkbox"/> Partial or full removable dentures |
| <input type="checkbox"/> Sensitive teeth | <input type="checkbox"/> Burning tongue | <input type="checkbox"/> Daytime or nighttime clenching or grinding of the teeth | <input type="checkbox"/> Food collecting under bridges or dentures |
| <input type="checkbox"/> Cold | <input type="checkbox"/> Teeth or fillings staining or yellowing | <input type="checkbox"/> Lip or fingernail biting | <input type="checkbox"/> Teeth shifting or moving |
| <input type="checkbox"/> Hot | <input type="checkbox"/> Sore jaw muscles or joints | <input type="checkbox"/> Orthodontic treatment | |
| <input type="checkbox"/> Sweets | | <input type="checkbox"/> Periodontal (gum) treatment | |
| <input type="checkbox"/> Biting pressure | | | |

Please check if you have been thoroughly instructed in the following:

- Proper brushing and flossing techniques Cause and prevention of dental decay Cause and prevention of periodontal (gum) disease

Please list any specific complications with dental treatment: _____

Please describe any past bad experience: _____

Please check one:

1. My mouth is: very comfortable
 moderately comfortable
 uncomfortable
2. I think the appearance of my mouth is excellent
I am satisfied with the appearance of my mouth
 dissatisfied with the appearance of my mouth
3. I will do anything to keep my natural teeth
 want to keep my teeth, but have a certain budget of time and money that I am willing to invest
 don't care whether I keep them or not
4. I have set goals for my oral health with my previous dentist
 want to set goals concerning my dental health
 don't care about setting goals concerning my dental health
5. I have put dentistry for myself and my family high on my priority list
 put dentistry for myself and my family low on my priority list
 it's on my list, but it's hard to find
6. I think my present state excellent
of dental health is good
 somewhere between good and poor
 poor

What is your chief concern or reason for this visit? _____

What are some questions about dentistry and oral health that you have never had adequately answered? _____

Please check off the areas below which you have questions about or are interested in learning more about.

- | | | |
|--|--|---|
| <input type="checkbox"/> Periodontal disease (cause and prevention) | <input type="checkbox"/> Bonded or porcelain inlays, onlays or crowns (caps) as alternatives to fillings | <input type="checkbox"/> Protective athletic mouth guards |
| <input type="checkbox"/> Gum recession | <input type="checkbox"/> Fixed and removable bridges | <input type="checkbox"/> Mouth ulcers |
| <input type="checkbox"/> Halitosis (bad breath) (cause and preventions) | <input type="checkbox"/> T.M.J. (temporomandibular joint) disorders | <input type="checkbox"/> Sealants |
| <input type="checkbox"/> Dental decay (cause and prevention) | <input type="checkbox"/> Dental malocclusion (abnormal bite) | <input type="checkbox"/> Fluoride |
| <input type="checkbox"/> Cosmetic dentistry | <input type="checkbox"/> Premature wearing-away of the teeth due to grinding | <input type="checkbox"/> Root canal (Endodontic) therapy |
| <input type="checkbox"/> Bonding | <input type="checkbox"/> Toothbrush abrasion | <input type="checkbox"/> Pregnancy and oral health |
| <input type="checkbox"/> Porcelain veneering | <input type="checkbox"/> Removable bridges or dentures | <input type="checkbox"/> Dental care for infants and small children |
| <input type="checkbox"/> Bleaching | <input type="checkbox"/> Orthodontics | <input type="checkbox"/> Nitrous oxide sedation |
| <input type="checkbox"/> Porcelain jacket crowns | <input type="checkbox"/> Wisdom teeth (3rd molars) | <input type="checkbox"/> Hospital dentistry |
| <input type="checkbox"/> Dental implants for replacement of single or multiple missing teeth | | <input type="checkbox"/> Dental Insurance |
| | | <input type="checkbox"/> Financing dentistry |

Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other. If yes, please explain: _____

Dr. Ken S. LeBlanc, D.D.S., P. C.
202 Rue Louis XIV, Lafayette LA. 70508

MEDICAL HISTORY

PATIENT NAME _____

BIRTH DATE _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? O Yes O No If yes, please explain _____

Have you ever been hospitalized or had a major operation? O Yes O No If yes, please explain _____

Have you ever had a serious head or neck injury? O Yes O No If yes, please explain _____

Are you taking any medications, pills, or drugs? O Yes O No If yes, please explain _____

Do you take, are have you taken, Phen-Fen or Redux? O Yes O No If yes, please explain _____

Are you on a special diet? O Yes O No If yes, please explain _____

Do you use tobacco? O Yes O No If yes, please explain _____

Do you use controlled substances? O Yes O No If yes, please explain _____

Women: Are you

Pregnant/trying to get pregnant? O Yes O No

Taking Oral Contraceptives? O Yes O No

Nursing? O Yes O No

Are you allergic to any of the following? Check all that apply

O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Local Anesthetics

O Other If other, please explain _____

Do you have, or have you had, any of the following: Check all that apply

- O AIDS/HIV Positive O Cortisone Medicine O Hemophilia O Renal Dialysis
O Alzheimer's disease O Diabetes O Hepatitis A O Rheumatic Fever
O Anaphylaxis O Drug Addiction O Hepatitis B or C O Rheumatism
O Anemia O Easily winded O Herpes O Scarlet Fever
O Angina O Emphysema O High Blood Pressure O Shingles
O Arthritis/Gout O Epilepsy or Seizures O Hives or Rash O Sickle Cell Disease
O Artificial Heart Valve O Excessive Bleeding O Hypoglycemia O Sinus Trouble
O Artificial Joint O Excessive Thirst O Irregular Heart Beat O Spina Bifida
O Asthma O Fainting/Dizziness O Kidney Problems O Stomach/Intestinal Disease
O Blood Disease O Frequent coughs O Leukemia O Stroke
O Blood Transfusion O Frequent Diarrhea O Liver Disease O Swelling of Limbs
O Breathing Problem O Frequent Headaches O Low Blood Pressure O Thyroid Disease
O Bruise Easily O Genital Herpes O Lung Disease O Tonsillitis
O Cancer O Glaucoma O Mitral Valve Prolapse O Tuberculosis
O Chemotherapy O Hay Fever O Pain in Jaw Joints O Tumors or Growths
O Chest Pains O Heart Attack O Parathyroid Disease O Ulcers
O Cold Sores/Fever Blister O Heart Murmur O Psychiatric Care O Venereal Disease
O Congenital Heart Disorder O Heart Pace Maker O Radiation Treatments O Yellow Jaundice
O Convulsions O Heart Trouble/Disease O Recent Weight Loss

Have you ever had any serious illness not listed above? O Yes O No If yes, explain _____

Comments: _____

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT or GUARDIAN _____ DATE ____/____/____