We would like to take this time to again welcome you to our office. We appreciate the confidence and trust that you have placed in us and look forward to a long dental relationship with you.

Our philosophy of care governs everything we do for you. It consists of the following key elements:

- **CARE :** We want you to feel very comfortable, we use the most modern technique ensure a pleasant experience everytime.
- **HEALTH :** We recognize that each patient is an individual and our goal is to help you maintain your teeth for a lifetime.
- **QUALITY :** We are always thorough at everything we do. We do not settle for less than 100%.
- **ESTHETICS:** Our goal is to provide you with not only functional but beautiful dentistry.

Please feel free to contact us with any of your dental needs or concerns. We are committed to being the best in our field.

Please visit our website at www.508DENTIST.com to learn more about us.

Thank you and we look forward to seeing you again soon,

Dr. G. Lepine and staff

***"LIKE"** us on facebook and receive 5% off your next procedure.*

HEALTH INFORMATION AND HISTORY

Date: _____

Patient's Name: _____

Date of Birth: _____

Social Security#: _____

Street Address: _____

City/Town: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Preferred Contact: ☐ Home Phone ☐ Cell Phone

Primary Insurance Co. Name & Address: _____

Subscriber Name: _____ **Subscriber Date of Birth:** _____

Subscriber ID #: _____ **Group #:** _____ **Employer:** _____

Secondary Insurance Co. Name & Address: _____

Subscriber Name: _____ **Subscriber Date of Birth:** _____

Subscriber ID #: _____ **Group #:** _____ **Employer:** _____

Emergency Contact: _____ **Phone:** _____ **Relationship:** _____

Primary Physician: _____ Phone: _____ City: _____

1. Within the last 3 years, have you been hospitalized or had surgery? □ Yes □ No

If yes, please give reasons and dates: _____

2. Have you ever been instructed to take ANY medications ANY special precautions before dental appointments? □ Yes □ No

If yes, please explain: _____

3. Are you taking ANY drugs, medications, or treatments at this time? □ Yes □ No

(If you brought a complete list with you, give that to the receptionist instead.)
Prescribed: _____

_____

Over-the-counter (OTC) medications (such as Advil, allergy medication, sleeping aids, etc.):

_____

Vitamins, natural or herbal preparations and/or dietary supplements:

_____

Are you having or have you ever had radiation or chemotherapy treatments? □ Yes □ No
If yes, for how long? _____ Name of facility performing treatment: _____

4. Are you taking or have you ever taken / been treated with a Bisphosphonate (Fosamax)? □ Yes □ No

5. Are you allergic to or have you ever had any reaction to any of the following?

___Penicillin (or related drugs)
___Clindamycin (Cleocin)
___Keflex (Cephalexin)
___Erythromycin
___Tetracycline
___Sulfa Drugs
___Barbiturates/Sleeping pills
___Tranquilizers (Valium)

___Aspirin/Ibuprofen (Advil, Motrin, Nuprin)
___NSAID (Celebrex, Vioxx, Anaprox)
___Metals or jewelry
___Dental anesthesia (local)
___Latex
___Fluoride
___General anesthesia
___Iodine

___Codeine
___Nitrous Oxide (laughing gas)
___Other(s) **Specify**
_____
_____
_____
_____

6. Do you have, or have you ever had, any of the following? (Please check Yes or No for each question.)

	YES NO		YES NO
Acid reflux	___ ___	Herpes/ cold sores	___ ___
Allergy - other	___ ___	High blood pressure	___ ___
Allergy - Codeine	___ ___	HIV	___ ___
Allergy - Penicillin	___ ___	Hormone replacement	___ ___
Anemia	___ ___	Infect endocarditis	___ ___
Angina/chest pains	___ ___	Jaundice	___ ___
Arthritis	___ ___	Kidney problems	___ ___
Artificial heart valve	___ ___	Liver problems	___ ___
Artificial joint/ prosthesis	___ ___	Low blood pressure	___ ___
If yes, what joint or area: _____		Lung disorder	___ ___
When was the operation done: _____		Lupus	___ ___
Anemia	___ ___	Mental Issues	___ ___
Asthma	___ ___	Mitral valve prolapse	___ ___
Atherosclerosis	___ ___	Organ transplant	___ ___
Cancer	___ ___	Osteoporosis	___ ___
Cong. heart failure	___ ___	Pacemaker	___ ___
Cong. heart defects	___ ___	Problematic snoring	___ ___
A compromised immune system	___ ___	If yes, would you like to be treated for it?	___ ___
Coronary artery disease	___ ___	Radiation therapy	___ ___
Diabetes (Type I or Type II)	___ ___	Rheumatic fever	___ ___
Emphysema	___ ___	STD	___ ___
Epilepsy/seizures	___ ___	Sinus problems	___ ___
Excessive bleeding from cut or incident	___ ___	Skin problems	___ ___
Glaucoma/eye disease	___ ___	Smoker	___ ___
Hay fever	___ ___	Sore/ wound no heal	___ ___
Heart surgery	___ ___	Stomach problems	___ ___
If yes, type & date_____		Stroke/ CVA	___ ___
Heart attack	___ ___	Thyroid problem	___ ___
If yes, date_____		Tuberculosis	___ ___
Heart murmur	___ ___	Ulcers	___ ___
Hemophilia	___ ___	Vertigo	___ ___
Hepatitis ☐A ☐B ☐C	___ ___	**WOMEN ONLY:**	
OTHER(s), conditions, diseases or medical problems	___ ___	Do you think you might be pregnant?	___ ___
_____		Are you using birth control medication?	___ ___
_____		Are you presently nursing?	___ ___
_____		Are you taking hormone replacement therapy?	___ ___

8. Why do you seek dental treatment? _____

9. Do you consider the condition of your oral health: Excellent ____ Good ____ Fair ____ Poor ____

10. When was your last dental visit? _____ **What was done?** _____

CONSENT – To the best of my knowledge, all of the preceding information is correct, and if there is ever any change in health or medications, this practice will be informed of the changes without fail. I also consent to allow this practice to contact any healthcare provider(s) and to have the patient's health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper health care and treatment to be performed by this practice for the above named individual until further notice. I understand there are no guarantees or warranties in health or dental care. I understand that all x-rays taken in this office shall remain the property of Lepine Dentistry, LLC. Should I desire a transfer of these records, I will be responsible for a duplicating fee. I understand that all charges are my ultimate responsibility. Non-sufficient funds fee is $50.00 and missed appointment fee is $75.00. I further understand that all balances remaining after insurance coverage (if any) has fulfilled its obligation are my responsibility. I understand that if I do not pay any amount which is owed you within 30 days after receipt of your statement of services rendered, then I will be in default of this agreement, and I will pay 18% interest and the reasonable cost which you incur to collect the balance owed you, including reasonable attorney's fees equal to 35% of the balance, allowed by the full extent permitted by law.

Signature_____ **Date**_____

(Parent or guardian, if patient is a minor)

Reviewed by: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices
(Please print Patient Name)

_____
(Patient Signature/ or Legal Guardian)

_____
(Date)

OPTIONAL PERMISSION TO SHARE WITH OTHER PARTY:

I, _____, give permission to Lepine Dentistry LLC and its representatives use/disclose the following protected health information to:

_____ _____
(Name) (Relationship to patient)

Please check off information to be disclosed:
____ Medical Records
____ Treatment Records
_____Diagnostic Records
_____Ledger/$-Account
_____other:_____

Expiration date or event terminating this permission:_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

This protected health information is being used or disclosed for the following purposes: