Welcome to our practice!

PERSONAL INFORMATION

NAME: ______________________________
FIRST MIDDLE INITIAL LAST

ADDRESS: ______________________ APT/LOT#: ______

____
CITY STATE ZIP

DOB: ___/___/___ SS#: ___-___-___ SEX: M F DL#/STATE: ________

HOME PHONE: __________ WORK: __________ OTHER: __________

EMPLOYER: ______________ OCCUPATION: __________

PERSON RESPONSIBLE FOR ACCOUNT: ______________

RELATIONSHIP TO PATIENT: __________ E-MAIL: __________

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: ______________

INSURED'S NAME: ______________ RELATIONSHIP: __________

DOB: ___/___/___ SS#: ___-___-___

EMPLOYER: ______________ OCCUPATION: __________

SUBSCRIBER I.D.#: __________ GROUP/CONTRACT#: __________

SECONDARY INSURANCE COMPANY: ______________

INSURED'S NAME: ______________ RELATIONSHIP: __________

DOB: ___/___/___ SS#: ___-___-___

EMPLOYER: ______________ OCCUPATION: __________

SUBSCRIBER I.D.#: __________ GROUP/CONTRACT#: __________

HEALTH INFORMATION

PLEASE CHECK ALL THAT APPLY:

- ☐ ACID REFLUX
- ☐ ARTIFICIAL JOINTS
- ☐ ANEMIA
- ☐ ASTHMA
- ☐ ASPIRIN ALLERGY
- ☐ BIRTH CONTROL
- ☐ BLOOD THINNERS
- ☐ BLOOD TRANSFUSION
- ☐ CANCER
- ☐ CHEMOTHERAPY
- ☐ CODEINE ALLERGY
- ☐ COLD SORES/FEVER BLISTERS
- ☐ DIABETIC
- ☐ EPILEPSY/SEIZURES
- ☐ GLAUCOMA
- ☐ HEART PROBLEM (SPECIFY)
- ☐ HEPATITIS-TYPE:
- ☐ HIGH/LOW BLOOD PRESSURE
- ☐ HIV/AIDS
- ☐ HYPO/HYPER GLYCEMIA
- ☐ IODINE ALLERGY
- ☐ JAUNDICE
- ☐ JOINT REPLACEMENT (SPECIFY)
- ☐ KIDNEY DISEASE
- ☐ LATEX ALLERGY
- ☐ MENTAL HEALTH/ PSYCHIATRIC DIAGNOSIS
- ☐ MITRAL VALVE PROLASPE
- ☐ NERVOUSNESS/DENTAL ANXIETY
- ☐ NOVOCAIN ALLERGY
- ☐ PENICILLIN/AMOX ALLERGY
- ☐ PREGNANCY DUE:
- ☐ RHEUMATIC FEVER
- ☐ SEXUALLY TRANSMITTED DISEASE
- ☐ STROKE
- ☐ THYROID MEDICATION
- ☐ T M J
- ☐ TUBERCULOSIS
- ☐ XYLOCAINE ALLERGY
- ☐ OTHER:

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HEALTH INFORMATION CONTINUED

DO YOU HAVE ANY HEART CONDITIONS THAT REQUIRE YOU TO BE PRE-MEDICATED (ANTIBIOTIC) BEFORE TREATMENT? IF SO, WHAT?
YES/NO____

HAVE YOU BEEN HOSPITALIZED WITHIN THE PAST 2 YEARS? IF SO, PLEASE EXPLAIN: **YES/NO**____

ARE YOU CURRENTLY BEING TREATED BY A PHYSICIAN? IF SO, FOR WHAT?
YES/NO____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS OR DRUGS? WHAT? **YES/NO**
____

HAVE YOU EVER RECEIVED COUNSELING FOR EXCESSIVE USE OF ALCOHOL AND/OR DRUGS, INCLUDING PRESCRIPTION? **YES/NO**____________________
____

ARE YOU ALLERGIC TO ANY DRUGS? WHAT? **YES/NO**____________________

ARE YOU ALLERGIC TO ANY METALS? WHAT? **YES/NO** ____________________

HAVE YOU EVER HAD A SKIN RASH OR OTHER REACTION TO METAL JEWELRY? TO WHAT? **YES/NO**____

HAVE YOU BEEN INVOLVED WITH A MEDICAL/DENTAL LEGAL ACTIVITY? **YES/NO**
____

DO YOU BLEED EXCESSIVELY UPON INJURY **YES/NO**

IN CASE OF AN EMERGENCY, WHOM SHOULD WE CONTACT?____________________
RELATIONSHIP:____________________ CONTACT #:____________________

HOW DID YOU HEAR ABOUT US?:____

ASSIGNMENT AND RELEASE:

I hereby authorize payment directly to **DR. MICHAEL J. LeBLANC** for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I am also financially responsible for any associated collection cost, penalty fees, and/or NSF charges that may be added to my account. I agree I am responsible for understanding my insurance benefits, frequencies and overall eligibility.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

SIGNATURE OF RESPONSIBLE PARTY:____

DATE:____

Our office strives to keep all records current. Please initial at each appointment to verify that the information on this sheet has been updated and is correct to the best of my knowledge:

INITIALS________DATE________ INITIALS________DATE________ INITIALS________DATE________ INITIALS________DATE________
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