FORUM DENTAL GROUP

Michael LaMarche, DDS

Diplomate of the American Board of Forensic Dentistry

PATIENT INFORMATION

Patient Name_____ Date of Birth _____ Gender: Male □ Female □

Social Security No._____

Marital Status: □Single □ Married □ Widowed □ Separated /Divorced □ Partner

Spouse's Name & Phone No. _____

Home Address _____

Billing Address (if different) _____

E-mail Address _____

Home Phone _____Cell Phone_____ Cell Phone Text Capable? _____

Occupation _____ Company Name_____ Work Phone_____

Which Phone Numbers would you like us to contact you? □Home □ ZCell □ Work

May we leave a detail message on your □Home □ Cell □ Work □ None

Emergency Contact Name _____Telephone _____

Relationship: _____

How did you hear about us?

□Existing patient of practice, Referred by _____

□ Internet/Web Search □ Office Website

□ yelp.com □ Other, please list_____

Person Responsible for This Account

□Patient OR □ other

If you check "Other", please provide the following information about the responsible person.

Name_____ Social Security No._____

Date of Birth_____ Relationship to Patient_____

Home Address _____

Home Phone _____Cell Phone _____ E-mail _____

Occupation _____ Company Name_____ Work Phone_____

Primary Insurance if you have a secondary insurance, please bring the card with you.

Insurance Company _____ Group / Policy No. _____

Subscriber's Name _____ Date of Birth_____

Social Security No. _____

Address _____

Subscriber's Employer _____Address _____

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DENTAL & MEDICAL INFORMATION

Reason for today's visit _____ Date of last dental care. _____ . _____

Former Dentist_____ Date of last dental X-rays _____

Former Dentist Phone No._____ Address _____

Are you currently under the care of a medical doctor? __ Yes __No If yes, please explain _____

Physician (Medical Doctor] Names _____ Phone Number._____ _____ . _____

Recent surgeries/Hospitalization_____

Prescription Medications:

1. _____ taking for _____
2. _____taking for _____

Over the Counter Medications:

l._ _____taking for_____

2._____.taking for _____

DENTAL HEALTH HISTORY

PLEASE MARK ANY THAT APPLY	*YES*	*NO*		*YES*	*NO*
Are you apprehensive about dental treatment?	._____		Chew on one side of your mouth?	____	____
Have you had problems with previous dental treatment?	____	___	Lip or cheek biting?	____	____
If yes, please explain_____			History of periodontal problems	_____	____
Do you smoke cigarettes, pipes or cigars?	____	___	Do you gag easily?	_____	____
Clicking/popping jaw/jaw pain or tiredness?	____	__	Do you wear dentures?	____	_____
Does food catch between your teeth?	____	___	Do you clench or grind?	____	____
' Are you dissatisfied with the appearance of your teeth?	____	___	Do you have sensitivity to sours?	_____	____
Do you have sensitivity to hot/cold foods or liquids?	____	___	Do you have sensitivity to sweets?	____	____
Do you have slow healing sores in your mouth?	____	___	Do you have loose teeth	___	____
Does your jaw get stuck so you can't open easily?	____	____	Do you have broken fillings	___	____

MEDICAL HEALTH HISTORY

PLEASE MARK ANY THA T APPLY

__Heart Problems	_Blood Problems	_Glaucoma	_Tuberculosis or other Respiratory
__Chest pain	_Easy bruising	_Stroke	_Fainting Spells, seizures, or epilepsy
__Shortness of breath	_Hemophilia/Bleeding Problems	_Herpes or other STD	_Persistent cough or swollen glands
__Blood pressure problem	_Anemia	_HIV positive or AIDS	_Hepatitis, jaundice, or liver trouble
__Heart murmur	_Previous blood transfusion	_Diabetes	_Radiation treatment
__Heart valve problem	_Asthma/Allergy	_Cancer or tumor	_Frequent or severe headaches
__Taking heart medication	_Inhaler	_Arthritis	_Do you wear contact lenses
__Pacemaker	_Joint or Bone Problems	_Thyroid problems	_Joint or Bone Problems
__Rheumatic fever	_Joint replacement		
__Artificial heart valve	_if yes, joint replaced when?		
__Mitral Valve Prolapse	_____		

Phone (425) 357-1818 15129 Main Street Suite 202 Mill Creek, WA. 98012-9036 Fax 866-586-348

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Have you ever taken in oral form or had I.V. bone density medications (for example Fosamax, Boniva, etc.)

If so, when did you take medication and for how long _____

Do you drink alcohol?

If so, how much/how often_____ : _____

Are you allergic or have you reacted adversely to any of the following?

	YES	*NO*		*YES*	*NO*
Local anesthetics, e.g. Novocain	____	____	Aspirin, acetaminophen, or ibuprofen	____	_____
Penicillin or other antibiotics	____	____	Codeine, Demerol, or other narcotics	____	_____
Sulfa drugs	____	____	Reaction to metals	____	_____
Barbiturates, sedatives, or sleeping pills	____	____	Latex or rubber dam	_____	_____

-WOMEN-

Have you reached menopause? *YES* *NO*

Are you taking contraceptives or other hormones? *YES* *NO*

Are you pregnant? *YES* *NO* If YES, expected due date

Are you nursing? *YES* ***NO***

Initial Blood Pressure:_____ Pulse:_____ O_2 Sat_____%

The above information is accurate and complete to the best of my knowledge. 1 will not hold my dentist or any member of his staff responsible for errors or omissions that I may have made in the completion of this form. Furthermore, 1 grant permission to Michael LaMarche, DDS and Staff to perform treatment as deemed professionally necessary. When local anesthetic is administered, I understand that the risks can involve heart palpitation, allergic reaction, hematoma, paresthesia, and drug cross-reaction. I further allow the release of my dental records from Dr. LaMarche to individuals involved in my dental care. I authorize individuals involved in my dental care to release to Dr. LaMarche any information pertaining to my dental care.

_____ _____

Patient /Guardian Signature **Date** **Provider's Signature** **Date**

There is a charge for appointments canceled or failed without a 48 hour advanced notice during the work week. Nitrous oxide sedation gas is available at a $48/hour charge.