Lake Norman
Cosmetic & Restorative Dentistry
Hoang H. Drouin, DMD, FAGD

Welcome

Thank you for selecting our dental healthcare team! We are commited to treating each person with compassion and excellence while restoring hope, health, and beautiful smiles. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask and we will be happy to help.

Patient Information (CONFIDENTIAL)

Check Appropriate Title ☐ Dr. ☐ Mr. ☐ Ms. ☐ Minor

Check Appropriate Box ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

First Name _____ Midle Name _____ Last Name _____

Preferred name to be called _____ SS # _____ Birth Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Alternate Daytime Phone Numbers _____

Email _____ Occupation _____

Patient's Employer _____ Work Phone _____

Hobbies/ Interests _____

If Patient is a Student, Name of School / College _____ City _____ State _____

Person to Contact in Case of Emerency _____ Phone _____

How do you prefer to recieve communication? ☐ Home ☐ Cell ☐ Work ☐ Email ☐ Text

How did you hear about us? ☐ Friend ☐ Doctor ☐ Internet ☐ Website ☐ Drive by/Sign
☐ General Word of Mouth ☐ Other _____

If personal referral, whom may we thank? _____

Spouse's Name _____ Occupation _____ Best Ph. # _____

Responsible Party (Fill out this section if patient is a minor.)

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Birth Date _____ Driver's License # _____ SS # _____

Employer _____ Work Phone _____

Is the Responsible Party Currently a Patient at Our Office? ☐ Yes ☐ No

Dental Insurance Information

Name of Subscriber _____ Relationship to Patient _____

Subscriber's Birth Date _____ ID # _____ Group # _____

Name of Employer _____ Work Phone _____

Insurance Company _____ Ins. Co. Ph. # _____ Fax # _____

Claims Address _____ City _____ State _____ Zip _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐ Yes ☐ No

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever been hospitalized for any surgical operation for serious illness?	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	☐	☐
4. Do you use tobacco? If yes, how much? _____ If yes, for how many years? _____	☐	☐
5. Do you use alcohol or any other recreational drug? If yes, please specify type and quantity _____	☐	☐

6. Are you allergic to, or have you had any reactions to the following:	Yes	No
Local anesthetics (e.g. Novocaine)	☐	☐
Penicillin or other antibiotic	☐	☐
Sulfa drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Latex	☐	☐
Other: _____		
7. Women only:		
Are you pregnant, or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking birth control pills?	☐	☐

Do you have or have you ever been diagnosed with any of the following conditions?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Stroke	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Mitro Valve Prolapse	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hayfever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Stomach Trouble / Ulcers	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilespy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement	☐	☐	Joint Implant	☐	☐
Thyroid Problems	☐	☐	Kidney Stone	☐	☐	Hepatitis / Jaundice	☐	☐
Respiratory Problems	☐	☐	AIDS / HIV Infections	☐	☐	Sexually Transmitted Dis.	☐	☐
						Snoring or Sleep Apnea	☐	☐

Patient Dental History

When was your last professional dental cleaning? ☐ 6 mo. or less ☐ 1 year ☐ 2-3 years ☐ 3-5 years ☐ Over 5 years

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold food/drink?	☐	☐
3. Are your teeth sensitive to sweet or sour food/drink?	☐	☐
4. Do you feel pain in any of your teeth?	☐	☐
5. Do you have any sores or lumps in or around your mouth?	☐	☐
6. Have you had any head, neck, or jaw injury?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
a) Clicking	☐	☐
b) Pain (joint, ear, side of face)?	☐	☐
c) Difficulty in opening or closing?	☐	☐
d) Difficulty in chewing?	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had a difficult extraction in the past?	☐	☐
12. Have you ever had any orthodontic work?	☐	☐
13. Have you ever had prolonged bleeding following extractions?	☐	☐
14. Have you ever had instructions on the correct method of brushing/flossing your teeth?	☐	☐
15. Have you ever had instructions on the care of your gums?	☐	☐
16. Have you ever considered whitening your teeth?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize my insurance company to pay insurance benefits directly to the dentist or dental group. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for full payment of all services rendered on my behalf or my dependents.

Signature _____ ***Date*** _____