John V. Louis, DMD, LLC
218 Bay Street
Easton, MD 21601
(410) 820-9599

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Your Address: _____
Street Apartment #

City _____ State/ZipCode _____ **EMAIL ADDRESS**: _____

Social Security #: _____ **Birth Date:** _____ **Family Status:** _____

Phone (Home): _____ (Work): _____ (Ext): _____ (Cell): _____

Dentists name _____

Date of Last Dental Visit: _____ Reason for this visit: _____

Physicians Name _____ Address _____

Preferred Pharmacy & Location _____

Health Information

Do you have, or have you ever had, or do you take any of the following? Please check those that apply:

- ☐ AIDS, ARC or positive test to HIV/HTLV III
- ☐ Addicted or recovering from drugs or alcohol
- ☐ Allergies _____
- ☐ Anemia
- ☐ Asthma
- ☐ Arthritis
- ☐ **Plavix ____mg**
- ☐ **Daily Asprin ___mg**
- ☐ **Coumadin ____mg**
- ☐ **Artificial Joints**
- ☐ **Bisphosphonates***
- ☐ Been denied permission to give blood
- ☐ Birth Control pills
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Cancer/chemotherapy
- ☐ Codeine allergy
- ☐ Contact with persons having TB or HIV
- ☐ Cortisone
- ☐ **Do you PRE-MED?**
- ☐ Diabetes-Pills/Insulin
- ☐ Dilantin
- ☐ Digitalis
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Emphysema
- ☐ Fainting
- ☐ Frequent urination (over 6 times per day)
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Hearing Difficulties
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Herbal Supplements or Vitamins(**please list**)
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Loss/gain ten pounds in the past year
- ☐ Penicillin allergy
- ☐ PhenPhen/reflox
- ☐ Pregnant or planning pregnancy
- ☐ Psychiatric Therapy
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Seizure/convulsions
- ☐ Shortness of breath
- ☐ Sinus Problems
- ☐ Surgery/Radiation of head or neck
- ☐ Stroke
- ☐ Sulfa allergy
- ☐ Syphilis
- ☐ Reaction to Novocaine
- ☐ Nitroglycerin or other medicine for angina pectoris
- ☐ Visual/hearing problems
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Osteoporosis
- ☐ Valium, Librium or tranquilizers
- ☐ Venereal Disease
- ☐ Do you smoke?____ How much ? _____
- ☐ Do you drink?_____ How much ?_____
- OTHER:
- ☐_____

LIST: Medications/Herbal/ Vitamin Supplements

List Starting Date:
Fosamax:
Didronel:
Boniva:
Actonal:
Skelid:

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ **Date:** _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice?

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Dental Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 2% per month (24% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that no waiver of any breach of any time or condition is extended and patient will be billed half of appointment time scheduled if not cancelled 48 hours prior to appointment . The broken appointment fee will be applied to the charges if scheduled within two months of broken appointment. Also shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ **Date:** _____ **Relationship to Patient:** _____
Signature of patient, parent or guardian

_____ **Date:** _____ **Relationship to Patient:** _____
Signature of guarantor of payment/responsible party

Occlusal Analysis Form

Yes	No	
___	___	1. Are you conscious of the way your teeth fit together?
___	___	2. Do you often clench your teeth?
___	___	3. Do you grind your teeth?
___	___	4. Do you often bite your cheek or tongue?
___	___	5. Have you ever worn a dental appliance to separate your teeth?
___	___	6. Have you ever had orthodontic therapy?
___	___	7. Do you have pain when chewing? Which side? (circle) Right or Left
___	___	8. Do you chew only on one side? Which side? (circle) Right or Left
___	___	9. Do you have any teeth that are particularly sensitive to hot or cold? Which side? (circle) Right or Left
___	___	10. Do you have difficulty opening your mouth wide?
___	___	11. Has your jaw ever been locked open?
___	___	12. Do you have (circle) CLICKING, POPPING or GRATING sounds from your jaw joint? Which side? (circle) Right or Left
___	___	13. Have you ever had pain from the jaw joint? Which side? (circle) Right or Left
___	___	14. Have you ever had pain around the ear not due to an ear infection? Which side? (circle) Right or Left
___	___	15. Do you suffer from frequent headaches? (circle) SINUS, VASCULAR, TENSION or OTHER
___	___	16. Do you frequently have neck pain? Which side? (circle) Right or Left
___	___	17. Do you frequently have STIFF MUSCLES or BACK PAIN?
___	___	18. Do you ever wake up with tired facial muscle?
___	___	19. Do you frequently experience stress at work or in your personal life?
___	___	20. Are you demanding of yourself at work or in your personal achievement?

Thank you,

John V. Louis, DMD, LLC