

Eastern Orthodontics & Pediatric Dentistry

Pediatric Dentistry

Jasper L. Lewis, Jr., D.D.S., M.S.
Joseph M. Gondrez, D.M.D.
W. Lee Lewis, D.D.S.

General Dentistry

James T. Casey, II, D.D.S.
Scott O. LaFevers, D.D.S.

Orthodontics

W. Lee Lewis, D.D.S.

THE FOLLOWING INFORMATION & HISTORY ARE NECESSARY FOR ADEQUATE TREATMENT & UNDERSTANDING OF THE PATIENT. THANK YOU FOR COMPLETING IT IN FULL.

Patient's Name Preferred Name Age
Sex Race Date of Birth Patient's Social Security #
Patient's Address Street City State Zip Home Phone #

Where Employed Cell Phone # Phone #

Spouse's Name Birthdate
Where Employed Phone #

Phone numbers for confirmation of appointment

Who is responsible for the account

Family Dentist Date of Last Cleaning

Address Patient's Physician

Whom may we thank for referring you to our office: Doctor Parent Patient Name of person referring patient

Address City State Zip

MEDICAL HISTORY

YES NO Is the Patient in good health?
YES NO Does Patient have any history of major illness?
YES NO Has the Patient ever been under the care of a physician for illness?
Please list:

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED:

- Diabetes Rheumatic Fever Asthma Endocrine Problems Fainting or Dizziness
Pneumonia Anemia Kidney Involvement Blood Disorders Nervous Disorders
Heart Trouble Epilepsy Liver Involvement Bone Disorders Tuberculosis
Other

YES NO Does Patient have a tendency to: Colds Sore Throats Ear Infections

YES NO Have tonsils and adenoids been removed? What age?

List any drugs or medications now being taken (give reasons):

List any allergies or drug sensitivity:

List any infectious diseases:

DENTAL HISTORY

YES NO Has there been injury to the face, mouth or teeth?
YES NO Does patient have any speech problems?
YES NO Is patient a mouth breather? While awake? While Asleep?
YES NO Has the patient been informed of any missing or extra permanent teeth?
YES NO Has an orthodontist been consulted previously?
YES NO Does the patient require antibiotic coverage for dental work?
YES NO Females only: Are you pregnant or trying to become pregnant?

List any musical instruments played:

Reason for consultation:

I agree to diagnostic procedures and dental treatments as found necessary and described by W. Lee Lewis, D.D.S. for the patient named above. I will accept responsibility for this account or any part thereof should named responsible party fail to pay the full bill.

Signature of responsible party: Date

Dental assistant reviewing history