Levesque Family Dentistry, PLLC
193 Kinsley Street
Nashua, NH 03060
Ph # : 603-882-7578
Fax # : 603-882-4215

Patient Personal Information

Title	Nickname	Birth Date	Age
Last, First		Marital Status	Sex
Address		Home #	Work #
		Cell #	Drive Lic
City, State, Zip		Student	SSN
Email		School Name	
		Referral Type	

Person responsible/guarantor for paying bills

Title	Nickname	Birth Date	Age
Last, First		Marital Status	Sex
Address		Home #	Work #
		Cell #	Drive Lic
City, State, Zip		SSN	
Email			

Do you have Primary Dental Insurance? No		Do you have Secondary Dental Insurance? __ Yes __ No	
Group No/Name		Group No/Name	
Insurance Name		Insurance Name	
Phone #		Phone #	
Employer Name		Employer Name	
Subscriber Last, First		Subscriber Last, First	
Subscriber Address		Subscriber Address	
City, State, Zip		City, State, Zip	
Relationship to Patient	Birth Date	Relationship to Patient	Birth Date
Subscriber ID		Subscriber ID	

Patient Medical Information

Allergic To

- ☐ Y ☐ N No Known Drug Allergies
- ☐ Y ☐ N Amoxicillin
- ☐ Y ☐ N Aspirin
- ☐ Y ☐ N Augmentin
- ☐ Y ☐ N Barbiturates / Sleeping Pills
- ☐ Y ☐ N Codeine
- ☐ Y ☐ N Epinephrine
- ☐ Y ☐ N Erythromycin
- ☐ Y ☐ N Ibuprofen
- ☐ Y ☐ N Iodine
- ☐ Y ☐ N Latex Rubber
- ☐ Y ☐ N Local Anesthetics
- ☐ Y ☐ N Metals
- ☐ Y ☐ N Naproxen

Check, if Yes

- ☐ Y ☐ N AIDS/HIV Infection
- ☐ Y ☐ N Alcohol/Drug Abuse
- ☐ Y ☐ N Anemia
- ☐ Y ☐ N Anorexia / Bulimia
- ☐ Y ☐ N Arthritis
- ☐ Y ☐ N Asthma
- ☐ Y ☐ N Blood Clotting Problems
- ☐ Y ☐ N Blood Transfusion
- ☐ Y ☐ N Bronchitis/Emphysema
- ☐ Y ☐ N Cancer / Tumor or Growth
- ☐ Y ☐ N Cardiac Pacemaker
- ☐ Y ☐ N Chest Pain Upon Exertion
- ☐ Y ☐ N Color Blindness
- ☐ Y ☐ N Damaged Heart Valve
- ☐ Y ☐ N Fever Blisters / Herpes
- ☐ Y ☐ N Frequent Headaches
- ☐ Y ☐ N Frequently Dry Mouth/Sjogrens
- ☐ Y ☐ N Gag Reflex
- ☐ Y ☐ N Glaucoma
- ☐ Y ☐ N Heart Attack / Stroke
- ☐ Y ☐ N Heart Disease / Angina
- ☐ Y ☐ N Heart Murmur
- ☐ Y ☐ N Hepatitis / Jaundice
- ☐ Y ☐ N High Blood Pressure
- ☐ Y ☐ N Joint Replacement
- ☐ Y ☐ N Kidney / Bladder Trouble
- ☐ Y ☐ N Liver Disease
- ☐ Y ☐ N Low Blood Pressure
- ☐ Y ☐ N Mental Health Problems
- ☐ Y ☐ N Rheumatic Fever
- ☐ Y ☐ N Sexually Transmitted Disease
- ☐ Y ☐ N Rheumatic Heart Disease
- ☐ Y ☐ N Seasonal Allergies
- ☐ Y ☐ N Scarlet fever
- ☐ Y ☐ N Shortness of Breath
- ☐ Y ☐ N Sinus Trouble
- ☐ Y ☐ N Stomach Ulcers
- ☐ Y ☐ N Thyroid Problems
- ☐ Y ☐ N Tuberculosis
- ☐ Y ☐ N Unusual Weight Loss

Office personel only

- ☐ Y ☐ N See Dental Questionnaire
- ☐ Y ☐ N See Medical Questionnaire

☐ Y ☐ N Penicillin	☐ Y ☐ N Diabetes	☐ Y ☐ N Mitral Valve Prolapse	☐ Y ☐ N See Scanned Documents: Pt Note
☐ Y ☐ N Sulfa Drugs	☐ Y ☐ N Epilepsy	☐ Y ☐ N Persistent Diarrhea	☐ Y ☐ N
☐ Y ☐ N Other _______________	☐ Y ☐ N Fainting Spells / Seizures	☐ Y ☐ N Premedicate	☐ Y ☐ N

Dental Questionnaire

Dental Questionnaire:

Name of previous Dentist ____________________

Phone ____________________

Date of last dental appointment ____________________

Date of your last x-rays ____________________

Check box if YES

Do your gums bleed while brushing or flossing ? ☐

Are your teeth sensitive to hot, cold or sweets ? ☐

Do you get frequent fever blisters, mouth ulcers, or sores on your lips or in your mouth ? ☐

Have you ever had burning of the tongue or cracking of the corners of your mouth ? ☐

Do you chew/smoke tobacco in any form ? ☐

Have you had any head, neck or jaw injuries ? ☐

Do you notice popping, clicking or soreness of the jaws? ☐

Do you clench or grind your teeth ? ☐

Have you ever had orthodontic treatment ? ☐

If Yes, date of placement ____________________

Do you wear dentures or partials ? ☐

If Yes, date of placement of dentures ? ____________________

Are you happy with your dentures ? ☐

Are you having any specific problems with your teeth, gums, or mouth at this time ? ____________________

Are you happy with your smile ? ☐

Do you regularly use dental floss ? ☐

Do you have difficulty in opening your mouth widely ? ☐

Do you have an unpleasant taste or odor in your teeth/mouth ? ☐

Do you want to learn to control your dental disease and retain your teeth ? ☐

Additional Comments ____________________

Medical Questionnaire

Family Physician ____________________

Phone ____________________

Are you currently under care of a Physician ? ____________________

If Yes, what ?	
If Yes, what is the condition being treated ?	
Have you had any serious illness, operation or been hospitalized within the past 5 years ?	
If Yes, what illness or problem ?	
Are you currently taking any medication ?	
If yes, what?	
Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast)	
Have you ever taken the diet control drug Fen-Phen ?	
Do you smoke ?	
How many?	☐
Women Only	
Are you pregnant?	
If Yes, what is your due date ?	
Are you currently nursing ?	
Are you on hormone replacement therapy ?	
Are you on birth control pills / fertility drugs ?	
Additional Comments	
Any Disease, Condition or Problem not Listed ? Please list	

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Signature **Date**