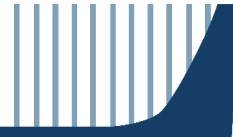


Lalane Dental



a family practice

2521 S. Federal Hwy
Boynton Beach, FL 33435

Robert A. Lalane II DMD
Charles J. Lalane DMD

561-735-3200
www.LalaneDental.com

Personal History

Today's date: ___ / ___ / ___

Name (Last, First): _____ Date of Birth: ___ / ___ / ____

Home Address: _____

City: _____ State: _____ Zip: _____

Telephone # Residence: (____) _____ Cell: (____) _____

Email address: _____

Employed By: _____ Occupation: _____

Spouse's Name: _____ Occupation: _____

Emergency contact: _____ Phone: _____

Whom can we thank for referring you? _____

Dental History

Date of last: Dental Visit: ___ / ___ / ____ Cleaning: ___ / ___ / ____ Full mouth X-rays: ___ / ___ / ____

Previous Dentist's Name: _____ Phone: (____) _____

Address: _____

What is your current dental problem? _____

YES NO

- | | | |
|--------------------------|--------------------------|--------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Are any of your teeth sensitive to HOT, COLD, SWEETS? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do your gums bleed when you brush your teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had gum or periodontal treatment? If so, when? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you noticed any loosening of your teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you clench or grind your teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever experienced any problem with you jaw (TMJ)? |
| <input type="checkbox"/> | <input type="checkbox"/> | a) Clicking of the jaw |
| <input type="checkbox"/> | <input type="checkbox"/> | b) Pain in your join, ear, or side of the face |
| <input type="checkbox"/> | <input type="checkbox"/> | c) Difficulty in opening or closing |
| <input type="checkbox"/> | <input type="checkbox"/> | d) Difficulty in chewing |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you satisfied with your smiling? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you like the color of your teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever whitened your teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you like the shape and size of your teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you like the straightness of your teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you like the way your gums look? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have unrestful sleep or awaken overly tired? |

- | YES | NO | I am interested in learning more about: |
|--------------------------|--------------------------|-----------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | a) Whitening |
| <input type="checkbox"/> | <input type="checkbox"/> | b) Veneers |
| <input type="checkbox"/> | <input type="checkbox"/> | c) Crowns |
| <input type="checkbox"/> | <input type="checkbox"/> | d) Bridges |
| <input type="checkbox"/> | <input type="checkbox"/> | e) Implants |
| <input type="checkbox"/> | <input type="checkbox"/> | f) Invisalign |

Medical History

Name of Physician _____ Are you in good health? _____

What conditions do you currently have? _____

MEDICATIONS THAT YOU ARE CURRENTLY TAKING _____

Do you Premedicate? ____ Yes ____ No _____

Do you have a drug allergy or had a reaction to a drug (EX. Penicillin, Codeine, dental anesthetic)? _____

Drug Allergies Include _____

Please indicate if any of these conditions apply to you:

- | YES | NO | |
|--------------------------|--------------------------|-----------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial heart valve |
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital heart valve defect or lesion |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney issues |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Hip or Knee replacement |
| <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker |
| <input type="checkbox"/> | <input type="checkbox"/> | History of cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | History of radiation therapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleed easily? |
| <input type="checkbox"/> | <input type="checkbox"/> | Taking blood thinners (ex. Aspirin, Pradaxa, Xarelto, Coumadin) |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Bisphosphonates (ex. Prolia, Fosamax, Boniva) |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy, Seizures or convulsions |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis (TB) |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergy to Latex (Rubber) |
| <input type="checkbox"/> | <input type="checkbox"/> | Sleep Apnea |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV positive/AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexually transmitted diseases |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you Pregnant? |

If you have a disease, problem, or condition not listed, please list

Dental Insurance, if any: Name of Company _____

Policy Number _____

Dental Insurance: New patients are required to pay in full at the time services are rendered. A claim will be submitted for the insurance company to reimburse you, provided the appropriate claim form and/or insurance card is given to the front desk. Thereafter, patients are expected to pay their percentage as well as any other balance not paid by the insurance company. Your signature below will be kept on file as your authorization for the release of information necessary to process your claim.

Broken Appointments: If you are unable to keep an appointment, kindly give us a **24-hour** notice so that we may schedule another patient and reschedule your appointment. Failure to do so may result in a broken appointment charge.

Signature (Parent, Patient, or Guardian) _____ Date ___/___/___