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

YES NO I am interested in learning more about:

☐ ☐ a) Whitening
☐ ☐ b) Veneers
☐ ☐ c) Crowns
☐ ☐ d) Bridges
☐ ☐ e) Implants
☐ ☐ 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

☐ ☐ Heart Attack
☐ ☐ Heart Surgery
☐ ☐ High Blood Pressure
☐ ☐ Low Blood Pressure
☐ ☐ Artificial heart valve
☐ ☐ Congenital heart valve defect or lesion
☐ ☐ Heart murmur
☐ ☐ Kidney issues
☐ ☐ Stroke
☐ ☐ Hip or Knee replacement
☐ ☐ Pacemaker
☐ ☐ History of cancer
☐ ☐ History of radiation therapy
☐ ☐ Bleed easily?
☐ ☐ Taking blood thinners (ex. Aspirin, Pradaxa, Xarelto, Coumadin)

☐ ☐ Osteoporosis
☐ ☐ Bisphosphonates (ex. Prolia, Fosamax, Boniva)
☐ ☐ Epilepsy, Seizures or convulsions
☐ ☐ Diabetes
☐ ☐ Tuberculosis (TB)
☐ ☐ Allergy to Latex (Rubber)
☐ ☐ Sleep Apnea
☐ ☐ Asthma
☐ ☐ Emphysema
☐ ☐ Hepatitis
☐ ☐ HIV positive/AIDS
☐ ☐ Sexually transmitted diseases
☐ ☐ 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.

Text-Messaging Opt-In: Please check the box below to give your consent and opt in to receive text messages from our dental office. By opting in, you agree to receive appointment reminders, important updates, requests for feedback/reviews and exclusive offers via text message. Standard messaging rates may apply. Message frequency may vary.

☐ I consent and opt in to receive text messages from Lalane Dental.

You can opt out at any time by replying STOP to any message.

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