Charles A. Lennon, DMD
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Patient Information

Complete Name: ____________________ Preferred Name: ____________________

Date of Birth: ____________ If under age 18, Name of Legal Guardian ____________________

Employer: ____________________ Type of work/profession ____________________

Gender: ☐ Female ☐ Male Marital Status: __________ Social Security Number:____________

Address: ____________________ City:__________ State: _____ Zip Code: _____

Telephone Numbers: Home: __________ Work: __________ Cell: __________

E-Mail address: ____________________

Please list any family members that are also our patients: ____________________

Health Information

Who may we thank for referring you? ____________________
Relationship to you: ☐ Dr. ☐ Family ☐ Friend ☐ Co-Worker

Have you ever had any of the following? Please check all that apply.

☐ Allergies ________	☐ Blood Disease	☐ Hepatitis	☐ Respiratory Problem
☐ Allergies Aspirin	☐ Cancer __________	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Allergies Codeine	☐ Diabetes	☐ HIV	☐ Rheumatism
☐ Allergies Erythro	☐ Dizziness	☐ Jaundice	☐ Sinus Problems
☐ Allergies Hay Fever	☐ Epilepsy	☐ Kidney Disease	☐ Stomach Problems
☐ Allergies Latex	☐ Excessive Bleeding	☐ Liver Disease	☐ Stroke
☐ Allergies Penicillin	☐ Fainting	☐ Mental Disorders	☐ Tuberculosis
☐ Allergies Sulfa	☐ Glaucoma	☐ Nervous Disorders	☐ Tumors
☐ Anemia	☐ Growths	☐ Pacemaker	☐ Ulcers
☐ Arthritis	☐ Head Injuries	☐ Pregnancy ____	☐ Venereal Disease
☐ Artificial Joints	☐ Heart Disease	Due:_________	☐ Other (please list)
☐ Asthma	☐ Heart Murmur	☐ Radiation Treatment	____________________

Have you ever had any complications following dental treatment? ☐ Yes ☐No
If yes, explain: ____________________

Have you ever been admitted to a hospital or needed emergency care during the past two years? ☐Yes ☐ No
If yes, explain: ____________________

Are you now under the care of a physician: ☐ Yes ☐ No
If yes, explain: ____________________
Name of physician: ____________________ Telephone: ____________________

Do you need to Pre-medicate? ☐ Yes ☐ No Example: Artificial Joints
If yes, explain: ____________________

Please list any medications you are currently taking: ____________________

Do you smoke? ☐ Yes ☐ No If yes, number of cigarettes/day: ____________________

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 or health conditions, I will inform the doctor(s) before or during my next appointment.

____________________ ____________________
Signature of Patient or Legal Guardian Date

Patient Registration Form

Dental History

Patient Name: ____ Date: ___________________

Reason for today's visit: ____

Date of last dental visit: ______________________ Date of Last Dental X-ray(s)______________

Please indicate if you have any of the following symptoms and/or habits:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Blisters on lips or mouth
- ☐ Burning Sensation on tongue
- ☐ Chew on one side of mouth
- ☐ Cigarette, pipe or cigar smoking
- ☐ Clicking or popping jaw
- ☐ Dry mouth
- ☐ Fingernail biting
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Gums swollen or tender
- ☐ Headaches
- ☐ Jaw pain or tiredness
- ☐ Latex allergy
- ☐ Lip or cheek biting
- ☐ Loose teeth/broken fillings
- ☐ Mouth breathing
- ☐ Missing teeth
- ☐ Mouth pain, brushing
- ☐ Orthodontic treatment, when: _____
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Sensitivity to cold or heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in mouth
- ☐ Stained or darkened teeth
- ☐ Worn or chipped teeth
- ☐ Other _______________________

Do you floss? _________________ How Often? _____________________

How often do you brush? _____________ ☐ Manual toothbrush ☐ Electric toothbrush

Are you happy with your smile? ☐ Yes ☐ No
If no, please describe what you do not like about your smile?

____

____

Insurance Policies

Patients who carry dental insurance are responsible for full payment at the time services are rendered. As a courtesy, this office will assist in the preparation of insurance forms and provide any necessary documentation to aid our patients in pre-determination from their insurance carrier. We are a participating provider on the CIGNA DENTAL PPO NETWORK. Other than the Cigna Plan, it is the responsibility of the patient to verify coverage with their carrier.

I have read and understand this policy. ____ ______________
Patient Signature **Date**

Primary Insurance:

Name of Insured: ____
Patient relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other___________________________________
Date of Birth: ____________________________ Social Security Number: ___________________
Employer:________________________________
Insurance plan name: ____ Telephone Number: __________________
Address: ____
City _____________________________ State: ________ Zip Code: ________________
Member ID: ________________________________
Group Name: _____________________________ Group Number: ______________

Patient Registration Form

Patient Name: ____ Date: _____________________________

Responsible Party Information

(Please complete this section only if different from the patient information)

Responsible Party Name: _______________________________________Relationship to patient: ___________________
Social Security Number: __________________ Driver's License Number: _____________________State:___________
Date of Birth:_____________ Gender: ☐ Female ☐ Male
Telephone Home: ____________________ Work: _________________________ Cell: _________________________
Address: _____________________________________City: ___________________ State: ____ Zip Code: ___________
Employer Name: ____

As the responsible party, you agree to pay in full at the time the services are rendered to the patient.

____ ____________________________
Signature of Patient or Legal Guardian Date

Office Policies – Please read policies and sign below

Appointments: Appointment times are reserved for you. We make every effort to reach you to remind you of your appointment. If you are unable to keep an appointment, we do require a 24-hour notice prior to canceling an appointment.

Payments: As a condition of your treatment by our office, payment is due in full at the time services are rendered. We are a 'fee for service' office and therefore require payment from patients for their care. You, or your legal guardian, are fully responsible for all fees charged regardless of your insurance coverage.

Treatment Plan Estimates: Fee estimates are based on the proposed treatment plan. We will make every attempt to plan accurately, but unanticipated situations or changes do arise and can affect treatment costs. Patients will be notified of applicable fees before services are rendered. A fee estimate is effective for 90 days.

Health Insurance Portability and Accountability ACT (HIPPA)
I acknowledge that I have read a copy of this office's Notice of Privacy Practices.

Permission to Use Facial Images
I do ______ or do not ______ agree to have visual images of my face, made in connection with my dental examination or treatment used for educational purposes. The visual images WILL NOT have your name attached to them.

____ ____
Signature of Patient or Legal Guardian Date

Emergency Contact Information

____ ____
Full Name (Please print) Relationship to Patient

____ ____
Telephone Number Cell Phone

I give Dr. Lennon permission to discuss my treatment and/or financial arrangements with your emergency contact person.

____ ____
Signature of Patient or Legal Guardian Date