Keizer Smile Center

Trenton LeBaron, D.M.D.

3975 River Rd. N. Ste. #5
Keizer, OR 97303

503-393-9106
www.keizersmilecenter.com

Patient name: _____ Date of birth: _____ Sex: _____

Home address: _____ City: _____ State: _____ Zip: _____

Billing address (if different): _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell/Text #: _____ Work phone: _____

E-mail: _____

How would you like to receive appointment reminders? (Circle all that apply): Text E-mail Home phone Work phone

Social Security #: _____ Employer/Occupation: _____

Spouse's name: _____ Guardian's name (if patient is a minor): _____

Emergency contact phone #: _____

Primary dental insurance: _____ Group #: _____

Secondary dental insurance: _____ Group #: _____

Subscriber's name: _____ Date of birth: _____ SS #: _____

Name of medical doctor: _____ Date of last visit: _____

Name of previous dentist: _____ Date of last visit: _____

Please mark any of the following you may have had, or have at present

- ☐ Stroke
- ☐ Congenital Heart Disease
- ☐ Artificial Heart Valve
- ☐ Pacemaker
- ☐ High / Low Blood Pressure
- ☐ Heart Attack or Heart Disease
- ☐ Blood thinning treatment
- ☐ Bruise easily
- ☐ HIV or AIDS
- ☐ Hepatitis or Liver Disease
- ☐ Venereal Disease
- ☐ Cold sores or herpes
- ☐ Tuberculosis
- ☐ Artificial Joint
- ☐ Surgical Prosthesis
- ☐ Ulcers/Stomach problems
- ☐ Kidney trouble
- ☐ Glaucoma
- ☐ Inner Ear disorders or Surgery
- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ Arthritis / Rheumatism
- ☐ Epilepsy or seizures
- ☐ Fainting or dizzy spells
- ☐ Cancer or related treatment
- ☐ Leukemia
- ☐ Psychiatric treatment
- ☐ Asthma
- ☐ Hay Fever
- ☐ Emphysema
- ☐ Allergies or Hives
- ☐ Sinus trouble
- ☐ Bisphosphonate Therapy

Do you or have you used:

Tobacco	Yes	No
Alcohol	Yes	No
Drugs	Yes	No
☐ Other _____		

For women only-

Are you pregnant?	Yes	No
Are you nursing?	Yes	No
Do you take birth control?	Yes	No

Have you ever been requested to take antibiotics or other medications before a dental appointment?	Yes	No
Is there anything else we should know about your health that is not covered in this form?	Yes	No
Would you like to speak with the doctor privately about any matter?	Yes	No

Please list all medications and/or dietary supplements you are currently taking:

_____

Please list any allergies to any medications: _____

I certify that the above information is complete and accurate. I also authorize Dr. LeBaron and those working with him to administer routine dental care including, but not limited to, dental X-rays and local anesthetics.

_____ _____

Patient Signature **Date**