Thomas W. Leslie, DDS

It is very important that we know the following information about you prior to any treatment.

Patient Information

Full Name: _____

Address: _____

_____ Zip Code: _____

E-mail: _____

Home Phone #: _____

Cell Phone #: _____

Date of Birth: _____ Sex: _____

Social Security #: _____

Guarantor/Spouse Information

Full Name: _____

Address: _____

_____ Zip Code: _____

Employer: _____

Address: _____

Work Phone: _____

Social Security #: _____

Date of Birth: _____

Employer Information

Employer: _____

Address: _____

_____ Zip Code: _____

Work Phone #: _____

Length of Employment: _____

If you or your spouse have dental insurance please fill out insurance information in box at right.

Insurance Information

Employee's Name: _____

Insurance Co.: _____

Address: _____

_____

Policy or Group #: _____

_____

Signature Date

We need your signature to send in forms for you.

If your spouse has another policy check here. ☐

Preferred way to contact you: ❑ Home Phone ❑ Work Phone ❑ Cell Phone ❑ E-mail

Health Questions

1. Is your general health good? yes no 2. Are you under a physician's care now? yes no

2a. Physician's name and address _____

3. Do you use tobacco products? yes no Are you interested in information about quitting? yes no

4. Are you currently taking any medications? yes no If yes, please list _____

5. Are you currently taking any blood thinners? yes no If yes, please list _____

6. Are you allergic to any medications? yes no If yes, please list _____

7. Do you have, or ever had any of the following:

❑ Heart disease	❑ Hepatitis	❑ Allergies
❑ Rheumatic fever	❑ Venereal disease	❑ Tumor or other growth
❑ Heart murmur/mitral prolapse	❑ HIV +/AIDS	❑ Shortness of breath on mild exertion
❑ Jaundice	❑ Scarlet fever	❑ Diabetes
❑ Epilepsy	❑ Stroke	❑ Chest pain on mild exertion
❑ High ❑ Low blood pressure	❑ Prolonged bleeding	❑ Kidney or liver disease
❑ Asthma	❑ Sinusitis	❑ Ulcer

8. Any other problem we should be aware of: _____

This information is strictly confidential and will not be released without your permission. The guarantor of this account is responsible for payment in full.

Signature: _____ Date: _____

*(Patient, parent or guardian **MUST** sign prior to treatment)*