JAMES T. LEON, D.D.S, INC.
PATIENT INFORMATION
(Please complete)

Name_____
(Last) (First) (Middle)

Name you prefer to be called_____ Mother's Maiden Name_____

Date of Birth_____ Social Security Number_____

Street Address_____ Apt. #_____

City_____ State_____ Zip Code_____

Home Telephone#_____ Work #_____ Cell #_____

Employer_____ E-mail Address_____

Whom may we thank for referring you?_____

Name of Spouse_____ Emergency Contact_____ Phone#_____

DENTAL INSURANCE INFORMATION

Primary Ins. Co. Name_____ Phone #_____
Ins. Billling Address_____City_____ State____ Zip_____
Insured's Name_____ Employer_____
Relationship to patient (self?)_____ DOB_____ SS#_____

MEDICAL HISTORY

Date of Last Physical Exam: ____/____/____
Are you now or have you recently been under a physician's care? ____Yes ____No
Reason:_____
Have you ever been a patient in a hospital or had any serious illness? _____Yes ____No
Explain:_____
Current Medications:_____
Allergies:_____

Check any of the following that you have had or suspected:

YES	NO		YES	NO		YES	NO	
___	___	Arthritis	____	____	Hepatitis or Jaundice	____	____	Prolonged Bleeding
____	____	Rheumatic Fever	____	____	Liver Disease	____	____	Fainting Tendency
____	____	Heart Trouble	____	____	Cancer or Tumor	____	____	Epilepsy
____	____	Heart Murmur	____	____	Tuberculosis	____	____	Thyroid Disease
____	____	High/Low Blood Pressure	____	____	Diabetes	____	____	Glaucoma
____	____	Chest Pain	____	____	Kidney/Bladder Trouble	____	____	Radiation Treatment
____	____	Stroke	____	____	Anemia	____	____	Mental Disorders
____	____	Shortness of Breath	____	____	Lung Disease	____	____	HIV or AIDS
____	____	Asthma or Hay Fever	____	____	Venereal Disease	____	____	Prosthetic Joint Replacement
____	____	Sinus Trouble	____	____	Blood Diseases	____	____	Blood Transfusion

Check any of the following that you are taking or have taken?

YES	NO		YES	NO		YES	NO	
_____	___	Cortisone Drugs	___	___	Anticoagulants	____	____	Tranquilizers
_____	____	Steroids	____	____	Blood Thinners	____	____	Sedatives

Women Only:
Are you pregnant?____Yes ____No If yes: How many months?____ Are you breast feeding?_____
Are you presently taking any routine medicine? (Birth control pills, shots, or implant, hormone therapy, etc.
Please explain:_____

The above information is true to the best of my knowledge.
RESPONSIBLE PARTY FOR PATIENT: Name and Address:_____

Signature:_____ Date:_____/_____/_____

THANK YOU FOR CHOOSING OUR OFFICE FOR YOUR DENTAL CARE NEEDS!