

**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. Billing 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  |
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**Check any of the following that you are taking or have taken?**

| YES | NO  | YES | NO  | YES | NO  |
|-----|-----|-----|-----|-----|-----|
| ___ | ___ | ___ | ___ | ___ | ___ |
| ___ | ___ | ___ | ___ | ___ | ___ |

**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:** \_\_\_\_/\_\_\_\_/\_\_\_\_