# Welcome to the Dental Office of Isabel Lyra-Leeds, DDS

Full Name:_____ Today's Date: _____

Date of Birth _____/_____/_____ Soc.Sec.Number : _____

Home Address: _____

City:_____ State:_____ Zip:_____

Cell#_____Home Phone#_____ Work Phone# _____

Employer:_____ Occupation: _____

Work Address: _____

E-mail Address:_____

Who Should We Thank For your Referral? _____

Emergency Contact:_____ Phone _____

## DENTAL HISTORY

Previous Dentist: _____ Date of Last Full Mouth XRays: _____

Office Phone: _____ Number Daily Flossing: _____ Brushing: _____

Address: _____ City _____State _____ Zip _____

Date of Last Dental Visit: _____ Reason forToday's Visit: _____

Mark Yes Only if Applicable

Do you Smoke?_____
How many a day?_____

Do you consume alcohol?_____
How many a day?_____

Do you have dry mouth?_____
Do you take an antidepressant? ____
Name_____/___mg per day

Bad Breath?_____ Periodontal disease?_____

Bleeding gums?_____ Do you have a toothache now?___

Sores or growths in mouth_____ Sensitivity to cold_____

Grinding or clenching teeth_____ Sensitivity to heat_____

Loose teeth_____ Sensitivity to sweet _____

Broken fillings_____ Sensitivity when biting _____

Orthodontic treatment?_____ TMJ pain _____

## MEDICAL HISTORY

Mark Yes Only if Applicable

AIDS _____
Anemia _____
Arthritis _____
Rheumatism ____
Asthma _____
Cancer _____
Stroke _____
Drug Addiction ___
Blood Transfusion___
Blood Disease ___
Venereal Disease___

Lung Disease _____
Rheumatic/ Scarlet Fever ____
Swollen Lymph Nodes ____
Allergies to Latex _____
Allergies to Penicillin _____
Any other Allergies _____
Glaucoma _____
Hepatitis _____
Herpes _____
Shingles _____
Tobacco Habit _____

HIV Positive _____
Pacemaker _____
Heart Surgery_____
Sinusitis _____
Ulcer _____
Tumor _____
Tuberculoses _____
Biopsy _____
Swelling Feet /Ankles_____
Cardio/Vascular Disease ___
Kidney Disease _____

Heart Murmur _____
Mitral Valve Prolapse ____
High Blood Pressure ____
Artificial Heart Valves ____
Liver Disease _____
Abnormal Bleeding _____
Cortisone Treatment _____
Psychiatric Care _____
Radiation Therapy _____
Fatigue/Dizziness _____
Chemotherapy _____

For Women Only
If Pregnant, number of weeks? _____

Do you take Birth Control?_____ If yes the name _____

Are you Menopausal ?_____

Have you been hospitalized during the last two years? _____

Reason:_____

Are you currently under physician care? _____

Explain: _____

Physician:_____Date of last visit _____

Physician address_____Tel_____

List of medication currently taking.

1-_____ Reason _____

2-_____ Reason _____

3-_____ Reason _____

Please note any medical condition which has not been mentioned. _____

I here by declare that the above information is true. I also state that I will notify Dr. Isabel Leeds' office immediately if any change occurs in my health.

Patient Signature or Guardian Today's Date

**R**oot **C**anal **T**reatment is a biological procedure which cannot be guaranteed. Root Canal Therapy is the last attempt at saving a tooth. Occasionally, **RCT** can result in root perforation, fracture of instrument, temporary or permanent paresthesia, trauma and/or hematoma of soft tissue. RCT could result in re-treatment, surgery and extraction of the tooth.

This office will not provide dental treatment without local anesthesia. Local anesthesia can result in temporary or permanent paresthesia. In addition, the remote risk of needle fracture during any injection of local anesthetic could occur. If fracture occurs, surgery may be necessary in order to remove the needle.

All dental procedures will be paid in full by patient or guardian if minor. Payment is due in full at the time treatment is provided. Financial responsibility lies solely with the patient or guardian. This office is not associated or affiliated with any Dental Network,Dental Union, American Insurance Companies, International Insurance Companies, private or governmental. NO INSURANCE ASSIGNMENT IS EVER TAKEN. Insurance refund will be reimbursed to patient once patient presents a positive balance after all dental treatment provided is fully paid.
Service taxes of 1 1/2 % monthly (18% per year) will be charge against all delinquent balance over 60 days.
I fully understand the above statement.

Patient Signature or Guardian Today's Date