

RAYMOND E. LaVIGNE, DDS



AND ASSOCIATES

March 31, 2010

637 First Bank Dr. • Palatine, IL 60067
(847) 359-1292

«Appt_Name»
«Appt_Add1»
«Appt_Street2»
«Appt_Add2»

Dear «Appt_Name»,

Thank you for calling our office. We look forward to meeting you and helping you with your dental care.

Dr. La Vigne is a graduate of Northwestern University Dental School and has over 30 years experience in a wide range of dental treatment. He has expertise in complex restorative dentistry and in handling the most challenging esthetic needs. Through his blend of compassion with thorough yet gentle techniques he is able to provide the kind of care that can lead to great results even for patients with very major problems and concerns. Our office emphasizes excellent patient education and communication. We are highly conscious of infection control and safety for everyone. We practice with a very sensible approach.

We are also a family practice treating patients of all ages. Our style is to provide needed dental care of any type from preventive and conservative through the entire range to complex restorative and replacement dental procedures including implants.

Your appointment is scheduled for «Appt_Date» at «Appt Time». The appointment will take approximately _____ hour / Minutes.

We will perform the following procedures for you:

- Comprehensive Exam Limited Exam to check a specific problem
 Full Mouth X-rays Bite Wing X-rays Limited X-rays as needed to diagnose any problems Limited consult for a specific problem or second opinion
 Prophylaxis (cleaning) Other _____

Please remember to bring the enclosed form with you at the time of your appointment. Also, **if you are transferring previous x-rays (full mouth x-rays within the last 5 years)** please arrange for them to be **sent to us prior to your first appointment or bring them with you**. When a good full mouth x-ray is available, we usually need to take a few routine yearly x-rays or supplemental x-rays only.

If you have dental insurance, please bring your current information card so that we can enter this into the computer. We will accept assignment of insurance for routine procedures when we are familiar with your insurance plan.

If you are unable to make the appointment you have scheduled with us, we would appreciate you notify us a minimum of 48 hours in advance.

Thanks again for choosing our dental practice.

Sincerely,

«Appt_Provider».

MEDICAL HISTORY

Physician: _____ City: _____ Phone# _____

Date of last physical exam _____ Are you taking any prescription

Medications _____ If yes, please list _____

Have you ever had or do you have any of the list below: Please check yes or no to each, circle appropriate condition in list.

	YES	NO
1. Asthma, hay fever, sinusitis		
2. Allergy to penicillin, erythromycin, aspirin, codeine		
3. Allergy to Latex, Other Allergies:		
4. Reaction to general or local anesthetic, nitrous oxide		
5. High or low blood pressure, heart failure, angina		
6. Pacemaker, artificial heart valve		
7. Rheumatic fever, heart murmur, artificial joint, implants		
8. Diabetes, kidney, thyroid or lung problems		
9. Ulcer, stomach or intestinal problems		
10. Hepatitis, Jaundice, liver problems		
11. Epilepsy, convulsions, head injury, fainting, stroke		
12. Other nervous disorder:		
13. Anemia, bleeding problem, blood disorder		
14. Frequent headaches, migraine, frequent earaches		
15. Venereal disease, herpes		
16. Back pain, arthritis, orthopedic treatment		
17. Acquired immune deficiency syndrome, aids, HIV positive		
18. Slow healing, surgical complications		
19. Frequent canker sores, bleeding gums, mouth odor		
20. Smoking, chewing tobacco		
21. Alcohol (more than 10 drinks per week) street drugs		
22. Previous major surgery:		
23 Radiation treatment, chemotherapy		
24. Taking insulin, thyroid, hormones, steroids		
25. Pregnant? Due date:		
26. Other:		

I have answered the medical history honestly and completely. I will inform the doctor of any future changes. I understand that this form is strictly confidential. I authorize the doctor to take x-rays and any other diagnostic information deemed appropriate.

Patient or Parent Signature

Date

Dr.'s initial.

REGISTRATION AND MEDICAL HISTORY

Today's Date: _____ Patient's Name: _____
Age: _____ Date of Birth: _____ F M SS# _____
Home Address: _____ City: _____
Zip Code: _____ Home# _____ Cell # _____

PERSON FINANCIAL RESPONSIBLE: _____
Address if different then above: _____
Employer: _____
Address: _____ Work # _____
Home# _____ Cell# _____
Email _____ Driver's Lic# _____

How did you hear about our office (Patient, Relative, Yellow book, SBC book, Insurance Company)

DENTAL INSURANCE INFORMATION

Primary Insurance Carrier _____
Name of Employer: _____
Name of Employee: _____
ID # of Employee: _____ SS# of Employee _____
Group # _____ Contract year: _____ Phone # _____
Amt of coverage: \$ _____ Deductible: \$ _____

Secondary Insurance Carrier _____
Name of Employer: _____
Name of Employee: _____
ID # of Employee: _____ SS# of Employee _____
Group # _____ Contract year: _____ Phone # _____
Amt of coverage: \$ _____ Deductible: \$ _____

We plan our appointments carefully in advance and strive very hard to stay on schedule so please help us by being on time. Our policy is a 48 hour advance notice if you need to change or cancel an appointment. A fee will be applied for broken appointments without a 48 hour notification.

I am responsible for this account, including all balances unpaid by my insurance. I understand that payment is due at the time services are rendered unless a financial arrangement has been made in advance. I further understand that a finance charge will be added to any overdue balance.

Patient Signature or if under 18, parental guardian

Please continue to other side