Leonard Lem, M.D., D.D.S.
Oral, Maxillofacial & Implant Surgeon
i-CAT Imaging

PATIENT REGISTRATION: (All information given will be kept confidential.)

Patient's name: _____ Date of Birth:_____

Social Sec.#: _____ Driver's License#: _____

( ) Male ( ) Female ( ) Single ( ) Married ( ) Divorced ( ) Other

Home Address: _____City:_____State_____Zip_____

Tel (H): _____Tel (Cell): _____

Tel (W): _____Ext. (If Any):_____

Employer/School:_____Occupation: _____

Bus Address: _____City_____State_____ ZIP_____

Purpose of this appointment: _____

Payment Mode: ( ) Cash ( ) Check ( ) Credit Card ( ) Insurance

How were you referred to us: _____

For emergency, contact: _____ Tel: _____

SPOUSE / PARENT INFORMATION: (Circle One)

Name of Spouse/Parent : _____ Date of Birth:_____

Social Security No .(SS#):_____

Employer : _____ Work # _____

Bus. Address : _____ City: _____ State:_____ Zip:_____

DENTAL INSURANCE INFORMATION:

Insured's name:_____ Relationship:_____

Insured's SS#: _____ Insured's Birth date: _____

Insurance Co. Name: _____Insurance Co. Tel. #: _____

Insured's employer: _____

I understand that I am responsible for payment of services rendered, including consultation and x-rays. I agree to pay for any co-payment and deductible which my insurance does not cover. Co-payment and deductible are due at the time of treatment unless prior arrangements have been made. I also assign payment or benefit from my insurance company directly to Dr. Leonard Lem. Past due balance (over 90 days) will be subject to 1% monthly interest charge which is 12% annually.

Your Signature:_____ Date:_____

SECONDARY DENTAL INSURANCE INFORMATION:

Insured's Name:_____Relationship: _____

Insured's SS#: _____Insured's Birth date_____

Insurance Co. Name:_____ Insurance Co. #:_____

Insured's Employer & Address:_____

MEDICAL INSURANCE INFORMATION:

Insured's Name:_____Relationship:_____

Insured's SS#: _____Insured's Birth date_____

Insurance Co. Name:_____ Insurance Co. #:_____

Employee's I. D. # (if any):_____

HEALTH HISTORY:

1. Your current physical health is: ( ) Good ( ) Fair ( ) Poor

2. Physician's Name: _____ Phone #: _____

3. DENTIST'S NAME: _____**PHONE** _____

4. Please list any medical conditions or previous hospitalizations:

_____
_____
_____

5. Please list current medication and dosage:

_____
_____

6. Are you **ALLERGIC** to any medications: ( ) Yes ( ) No Please list:

_____

7. For Woman: Are you pregnant: ( ) Yes ( ) No Weeks #: _____

8. Do you smoke? ( ) Yes ( ) No.

9. Do you have or have you ever had:

Yes	No		Yes	No	
_____	_____	Asthma	_____	_____	Hemophilia
_____	_____	Cancer	_____	_____	Abnormal Bleeding
_____	_____	Diabetes	_____	_____	Hepatitis
_____	_____	Difficulty Breathing	_____	_____	High Blood Pressure
_____	_____	Drug/ Alcohol Abuse	_____	_____	HIV+ / AIDS
_____	_____	Fever Blisters/ Herpes	_____	_____	Kidney Problems
_____	_____	Heart Attack / Stroke	_____	_____	Severe Headaches
_____	_____	Heart Surgery	_____	_____	Sinus Problem
_____	_____	Pain/discomfort in your jaws joint (TMJ)	_____	_____	Blood Transfusion
_____	_____	Teeth sensitive to heat, cold or anything else			

Others (Please specify):_____