Raymond E. Lawrence, D.M.D.,LLC
229 East Center Street
Manchester, CT 06040
(860) 643-0688

Patient's Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Home(___)_____Wk(___)_____Cell(___)_____
Where do you prefer to receive calls:_____
Email: _____

MEDICAL HISTORY **YES NO**

Are you under medical treatment now?		
Have you been hospitalized for any surgery/illness in the past 6 years?		
If yes, please explain:		
Do you use tobacco?		
If yes, how much and how often?		
Do you consume more than 2 alcoholic beverages per day?		
The following three questions are for women only:		
Are you pregnant or think you may be pregnant?		
Are you nursing?		
Are you taking oral contraceptives?		

Are you allergic or have had reactions to any of the following? (please circle)

Penicillin or other antiobitics		*Metals (nickel, mercury, etc.)*
Sulfa drugs	*Aspirin*	*Iodine*
Barbiturates	*Sedatives*	*Latex rubber*
Other (please list)		

Please list ALL medications you are currently taking:

Medication	Dose	Reason

Dental History **Yes No**

Do your gums bleed while brushing/flossing?		
Are your teeth sensitive to hot or cold?		
Are your teeth sensitive to sweet or sour?		
Do you feel any pain in your teeth?		
Any sores or lumps in or near your mouth?		
Do you have frequent headaches?		
Do you clench or grind your teeth?		
Do you bite your lips or cheeks frequently?		
Have you ever had prolonged bleeding following dental procedures?		
Have you ever had any difficult extractions?		
Have you ever had orthodontic treatment(braces)?		
Do you wear dentures/partials? Date of placement?		
Have you ever had to take medication (antibiotics) prior to dental work?		
Are you satisfied with your smile?		

Have you ever experienced any of the following problems in your jaw? (Please circle)

Clicking Difficulty Chewing

Difficulty opening/closing Pain: joint, ear, side of face

Do you have any of the following conditions?

Frequently Tired	Low Blood Pressure	Recent Weight Loss
Epilepsy/Convulsions	Respiratory Problems	Mitral Valve Prolapse
Leukemia	Arthritis	Cancer
Liver Disease	Leukemia	High Blood Pressure
Joint Replacement	Diabetes	Kidney Disease
AIDS / HIV Infection	High Cholesterol	Sleep Apnea
Stomach Trouble / Ulcers	Snoring	Thyroid Problem
Chest Pains	Hepatitis	Osteoporosis
	Heart Disease	Easily Winded
Cardiac Pacemaker	Heart Attack	Stroke
Hay Fever / Allergies	Rheumatic Fever	Heart Murmur
Swollen Ankles	Angina	Tuberculosis
Fainting/Seizures	Asthma	Anemia
Radiation Therapy	Glaucoma	Emphysema
Other: Please list		

Signature _____ Date:_____

Patient Information:

Date of Birth: ___/___/___ SS: ___-___-_____

Occupation: _____ Employer: _____

Name of Spouse (or parent if minor): _____

Emergency Contact: _____ Phone: (____)_____

Whom may we thank for referring you to us? _____

Who is financially responsible for the account? _____
Relationship to patient: _____
Home: (___)_____ Work: (____)_____ Cell: (____)_____
D.O.B. ____/____/____ Age: _____
Is this person also a patient? Y / N

Insurance Information: ALL LINES MUST BE COMPLETED FOR US TO SUBMIT TO YOUR INSURANCE CARRIER

Name of Insured: _____ Policy/Group # _____ ID# _____

Date of Birth: _____/_____/_____ SS#: ____-____-_____

Date Employed: _____

Employer: _____ Insurance Carrier: _____

Claims Address: _____ Phone: (_____) _____