

We are pleased to welcome you and/or your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Date	Occupa	ation				
SS/HIC/Patient ID #	Patient	Employe	r/School_	1 20	R	
Patient Name	Employ	er/School	I Address			
Address						
City		er/School	l Phone (
State Zip						
E-mail				SS#		
Sex M F Age Birthdate Married Widowed Single	Minor			A A		
	d for years	may we th	hank for r	eferring you?		_
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	DENTAL INSU	RAN	VCE			
Subscriber's Name	Is patie	nt covere	d by seco	o <mark>ndary</mark> insurance? 🗌 Yes 🛛 No	1	
Relationship to Patient	Subscr	iber's Nar	me			
Birthdate SS#	Relation	nship to F	Pati <mark>ent _</mark>			<u></u>
Insurance Co.	Birthda	te		SS#		
	· ·			Phone () _		
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	PHONE NUN	1BEX	25			
		4				
Home ()	Work ()		Ext	Alt. ()		
		time and	place to	reach you		
IN CASE OF EMERGENCY, CONTACT (Specify s	THE PROPERTY OF THE PROPERTY O					
Name	Rela	tionship_		17		
Phone ()		1	Ext	Alt. Phone (
	A Company of the Comp				- 1, - 1	
	DENTAL HIS	TOR	RY			
Reason for today's visit	Please check ([🎤) "yes" or "no"			have had any of the following:		
	Bad breath	☐ Yes		Jaw pain or tiredness	☐ Yes ☐	
Former Dentist	Bleeding gums Blisters on lips or mouth	☐ Yes		Lip or cheek biting Loose teeth or broken fillings	STATE OF THE REAL PROPERTY OF THE PERTY OF T	No No
	Burning sensation on tongue	☐ Yes		Mouth breathing		No
City/State	Chew on one side of mouth	☐ Yes		Mouth pain	19-1-19-19-19-19-19-19-19-19-19-19-19-19	No
Date of last dental visit	Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Orthodontic treatment	☐ Yes ☐	No
Date of last dental X-rays	Clicking or popping jaw		☐ No	Pain around ear	☐ Yes ☐	
	Dry mouth	☐ Yes		Periodontal treatment		No
How often do you floss?	Fingernail biting Food collection between the teeth	☐ Yes		Sensitivity to cold Sensitivity to heat	Yes	
How often do you brush?	Foreign objects in mouth	☐ Yes		Sensitivity to near Sensitivity to sweets	Yes	
Do you wear contact lenses? ☐ Yes ☐ No	Grinding teeth	☐ Yes	The second second	Sensitivity when biting	☐ Yes ☐	
	Gums swollen or tender	☐ Yes		Sores or growths in mouth	☐ Yes ☐	
						140
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MEDICAL HISTORY

Please check ([P]" "yes" or "no" to indicate if you have had any of the following: AIDS	Physician's Name		188			Da	ate of last visit	
Please Check ([]**) "yes" or " fo indicate Ir you have had any of the following:	Phone ()	PharmacyPhone ()						
Anthreis, Riseumatism Yes No Hif Positive Yes No Asthma Yes No Jew Poin No No No No No No No N	Please check (🛩) "yes" or "no	o" to indic	cate if yo	u have had any of the following	j:			
Arthrist, Rheumeitism Yes No Jaundice Yes No Tumors or Growths Yes No Asthrist Yes No Asthrist Yes No No Yes		☐ Yes			and the same of	armediana armedi		☐ Yes ☐ No
Asthma Vss No Jave Pain Vss No Jave Pain Vss No Jave Pain Vss No Liver Diseases Vss No Revision Vss No No No No No No No	Anemia	☐ Yes	☐ No	HIV Positive	☐ Yes	☐ No	Tuberculosis	Yes No
Back Problems Yes No Kidney Disease Yes No Venernal Disease Yes No Yes Yes Yes No Yes Yes Yes No Yes Yes Yes Yes No Yes	Arthritis, Rheumatism	Yes	☐ No	Jaundice	☐ Yes	□ No	Tumors or Growths	
Back Problems vs No Kidney Disease vs No Venerual Disease vs No No No Venerual Disease vs No No No Venerual Disease vs No No No No No No No N	Asthma	☐ Yes		Jaw Pain			Ulcer	☐ Yes ☐ No
Cancer Yes No Liver Disease Yes No Chemotherapy Yes No Nervous Problems Yes No No No No No No No N	Back Problems	Section 1		Kidney Disease	The state of the s		Venereal Disease	☐ Yes ☐ No
Chemical Dependency Yes No No Roy No No No No No No No							437	200 00 12 22
Chemotherapy Ves No Nervous Problems Ves No Corrisone Treatments Ves No Radiation Treatment Ves No Corrisone Treatments Ves No Radiation Treatment Ves No Corrisone Treatments Ves No Radiation Treatment Ves No No Corrisone Treatments Ves No Radiation Treatment Ves No No Corrisone Treatments Ves No Radiation Treatment Ves No No Corrisone Treatments Ves No No Corrisone Ves No Corrisone					San		Have you ever had or been	
Circulator Problems Ves Mo Reginatory Problems Ves Mo Artificial Heart Valves Ves Mo Contrains Treatments Ves Mo Reginatory Diseases Ves								
Cortison Treatments Yes No Radiation Treatment Yes No Artificial Joints, Screws, Yes No Diabetes Yes No No Diabetes Yes No Scarlet Fever Yes Yes		Marine e.	All more again.		Section 19		and the same of th	□ Voc □ No
Cough, persistent or bloody Yes No Respiratory Disease Yes No Pins, etc. Yes No Diabetos Yes No Scardet Fever Yes No Semphysema Yes No Shortness of Breath Yes No Shortness Yes								☐ 169 ☐ 140
Diabetes Yes No Scarlet Fever Yes No Blooding abnormally, with extractions or surgery Yes No Epilepsy Yes No Shortness of Breath Yes No Blood Disease Yes No Shortness of Breath Yes No Short		100000000000000000000000000000000000000				a Classical Control of the Control o	A STATE OF THE STA	□Vaa □N-
Emphysema Yes No Shortness of Breath Yes No Survey Yes No Sirus Trouble Yes No No Heard Brown Trouble Yes No Firus Trouble Y					The second second			☐ Yes ☐ No
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Glaucoma Yes No Spocial DistWeight Los Yes No Hearti Amurrur Yes Meadaches Yes No Stroke Yes No Stroke Yes No Mittal Valve Prolages Yes No No No No No No No N				Skin Rash			Congenital Heart Lesions	☐ Yes ☐ No
Header Problems vss No Stroke vss No Mitral Valve Prolatises vss No Pacemaker v	100 m	Comment (Comment			(E		Heart Murmur	☐ Yes ☐ No
Heart Problems vs No Swollen Feet or Ankles vs No No Swollen Feet or Ankles vs No Herpestitis Type vs vs No No Herpestitis Type vs vs No Thyroid Problems vs No Herpestitis Type vs No No No No No No No N							Hernia Repair	
Hepatitis Type Yes No Swollen Neck Glands Yes No Rheumatic Fever Yes No Herpes Yes No Tryold Problems Provided Problems No Rheumatic Fever Yes No Rheumati		1 Carrier 10 100 100			San			
Herpes Ves No Thyroid Problems Ves No Aneumatic Fever Ves No Rave you ever had any complications Have you ever taken any of these medications? Ves No Subtractions? Ves No Couradin Ves Couradin Ves Couradin Ves Couradin							and the second of the second o	
Have you ever had any complications following dental treatment? Yes No No Modals (It yes, please describe								
If yes, please describe	Herpes	Yes Yes ✓	∐ No	Thyroid Problems	∐ Yes	∐ No	mileumanc rever	☐ tes ☐ No
If yes, please describe	Have you ever had any comp	olications		Have you ever taken any of t	hese		Are you allergic to:	
If yes, please describe								☐ Yes ☐ No
Tyes, please describe					□Yes	No	The state of the s	
Warfarin Yes No Duprofen Germany Warfarin Yes No Duprofen Germany Warfarin Yes No Duprofen Germany Warfarin Yes No Latax Yes No Latax Yes No Germany Yes No Devention Yes No Metals (i.e., gold) Germany Yes No No Metals (i.e., gold) Germany Yes No Metals (i.e., gold) Germany Yes No Metals (i.e., gold) Yes No Metals (i.e., gold) Yes No No Metals (i.e., gold) Yes No No Metals (i.e., gold) Yes No No No No No No No N	It yes, please describe							
Have you ever been hospitalized or do you have any other health concerns? Yes No Deptendent No Deptenden								
any ofher health concerns? \(\foatsize \) No Dextenfluramine \(\foatsize \) No Local Anesthesia \(\foatsize \) No Redux \(\foatsize \) No No No No No No No No	Have you ever been been been been	or do :	hous				Column Nation (NATIONAL STATE OF STATE	
If yes, please describe		,			ADHED			probable as an array of the standard or or
Pondimin	any otner nealth concerns?	Yes Yes ✓	∐ No		ASSESSED			
Women: Are you pregnant? yes No Levoxyl yes No Other Please PRINT all medications now taking: P	If yes please describe			The 10th and a 111th of 1100 hours are the same	Yes		Metals (i.e. gold)	☐ Yes ☐ No
Women: Are you pregnant? yes No Levöxy yes No No Yes No Yes No No Yes No No No No No No No N	ii yos, piease describe			Pondimin	Yes	☑ No		☐ Yes ☐ No
Women: Are you pregnant?				Redux	Yes			_
Due date	Women: Are you pregnant?	☐ Yes	□ No.					
Due date							Please PRINT all medications	now taking:
Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva.	Due date			The control of the co				
Taking birth control pills?	Are you nursing?	Yes	☐ No					:
To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. Insurance Assignment: I certify that I, and/or my dependent(s), have insurance coverage with Dr								
DOCTOR'S COMMENTS & UPDATE (to be completed by the dentist) dedical Clearance Letter Sent to	Dr. charges whether or not paid by inst. The above-named doctor may use obtaining payment for services and one year from the date signed below. Authorization to Release Protecte. Dr	urance. I aut my health c determining w. ed Health Ir and/or discle formation to current treat be protected if I do revoke	all insuhorize the lare information to us to us be used a timent plan id by federa e this author	urance benefits, if any, otherwise payabuse of my signature on all insurance su ation and may disclose such information benefits or the benefits payable for relations. I understand that there may be a need and/or disclose my Protected Health the information will be used and/or disclosed. I authorize Drund/or disclosed. Is completed or one year from the date so I privacy regulations. I understand that prization, it will not have any effect on an	Ibmissions. In to the above ated services. In to the above ated services. In to the above ated services. Information (Formation (For	e-named Ins This conser ith other hea PHI) related urpose of _ ne of Doctor understand this authorized by the abo	surance Company(ies) dered. I understand that I am financial surance Company(ies) and their agent at will end when my current treatment alth care providers. I voluntarily author to Describe in detail the Protected Describe each purpose for which y to receive and use the Receiving PHI that once the information is released it action at any time by notifying, in writin ove-named doctor disclosing the PHI pro-	ly responsible for all s for the purpose of plan is completed or ze Health Information rou are authorizing e information. may be re-disclosed g, the above-named
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