

Welcome

We are pleased to welcome you 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

Name					Soc. Sec. #	
	Last Name	First Na	me	Initial		
Address						
					Home Phone	
Cell Phone			Email			
Sex □ M □ F Age		Birthdate		_ 🗆 Single 🗅 Married	☐ Widowed ☐ Separated ☐ Divorced	
Patient Employed by_					Occupation	
Business Address					Business Phone	
						14
				Business Phone		
Email						
			Prima	ary Insurance		
			1.1111	a y modranec		
Person Responsible fo	or Account	Las	st Name		First Name	Initial
					_ Soc. Sec. #	
					_ Home Phone	
				State	5 Co. • Co.	
Cell Phone					_ Email	
Person Responsible E	mployed by				_ Occupation	
Business Address					Business Phone	
Business Email						
Insurance Company _					Phone	
Insurance Email						
					Subscriber #	
Name of other depend					46 (0.000)	
			Additio	onal Insurance		
Is patient covered by	additional insurance	? □ Yes □ No)			
Subscriber Name			Relation to Pati	ient	Birthdate	
Address (if different fr					2. #	
-				0000	Home Phone	
Cell Phone					_ Email	
Subscriber Employed					Business Phone	
Business Email					Duanicas i none	
					Dhona	
Insurance Email					Phone	
					0.1 1 1 1	
					Subscriber #	
name of other depend	ients under this plan					

Please complete both sides.





Dental History

What would you like us to do today?_		Are you in dental discomfort today?								
Former Dentist	Address									
Dentist's Email	Phone									
Date of last dental care Date of last x-rays										
Check (✓) yes or no if you have had problems with any of the following:										
□ Y □ N Bad breath □ Y □ N Food collection between teeth □ Y □ N Periodontal treatment □ Y □ N Sensitivity to sweets										
☐ Y ☐ N Bleeding gums	☐ Y ☐ N Grinding or clenching teeth	\square Y \square N Sensitivity to cold \square Y \square N Sensitivity when biting								
☐ Y ☐ N Clicking or popping jaw	\square Y \square N Loose teeth or broken fillings	\square Y \square N Sensitivity to hot \square Y \square N Sores or growths in mouth								
How often do you brush? Floss?										
How do you feel about the appearance of your teeth?										
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? \square Y \square N										
Other information about your dental health or previous treatment										
Medical History										
0.45										
Date of last visit	Have you had any serious	illnesses or operations? $\square Y \square N$								
If yes, describe										
	rre? 🗆 Y 🗀 N If yes, describe									
Have you ever had a blood transfusion		te dates								
Have you ever taken Fen-Phen/Redux? □ Y □ N										
Women: Are you pregnant? ☐ Y ☐		rth control pills?								
Check (✓) yes or no whether you l ✓ Y □ N AIDS/HIV Positive	have had any of the following: \[\sum Y \subseteq N \] Cough, persistent	☐ Y ☐ N Jaw pain	☐ Y ☐ N Shingles							
☐ Y ☐ N Anaphylaxis	☐ Y ☐ N Cough up blood	☐ Y ☐ N Kidney disease or	☐ Y ☐ N Shortness of breath							
☐ Y ☐ N Anemia	☐ Y ☐ N Diabetes	malfunction	☐ Y ☐ N Skin rash							
☐ Y ☐ N Arthritis, Rheumatism	□ Y □ N Epilepsy	☐ Y ☐ N Liver disease	☐ Y ☐ N Spina Bifida							
☐ Y ☐ N Artificial heart valves	□ Y □ N Fainting	☐ Y ☐ N Material allergies	□ Y □ N Stroke							
☐ Y ☐ N Artificial joints	☐ Y ☐ N Food allergies	(latex , wool, metal, chemicals)	☐ Y ☐ N Surgical implant							
□ Y □ N Asthma	☐ Y ☐ N Glaucoma	☐ Y ☐ N Mitral valve prolapse	☐ Y ☐ N Swelling of feet							
☐ Y ☐ N Atopic (allergy prone)	☐ Y ☐ N Headaches	☐ Y ☐ N Nervous problems	or ankles							
☐ Y ☐ N Back problems	☐ Y ☐ N Heart murmur	☐ Y ☐ N Pacemaker/	☐ Y ☐ N Thyroid disease or							
☐ Y ☐ N Blood disease	☐ Y ☐ N Heart problems	Heart surgery	malfunction							
☐ Y ☐ N Cancer	Describe	 □ Y □ N Psychiatric care 	☐ Y ☐ N Tobacco habit							
☐ Y ☐ N Chemical dependency	☐ Y ☐ N Hemophilia/	☐ Y ☐ N Rapid weight gain or loss	☐ Y ☐ N Tonsillitis							
☐ Y ☐ N Chemotherapy	Abnormal bleeding	☐ Y ☐ N Radiation treatment	☐ Y ☐ N Tuberculosis							
☐ Y ☐ N Circulatory problems	□ Y □ N Herpes	☐ Y ☐ N Respiratory disease	☐ Y ☐ N Ulcer/Colitis							
☐ Y ☐ N Cortisone treatments	□ Y □ N Hepatitis□ Y □ N High blood pressure	☐ Y ☐ N Rheumatic/Scarlet fever	☐ Y ☐ N Venereal disease							
	a i a iv filgii blood pressare									
Is patient currently taking any medica	ttions? If yes, list all:	Does patient have drug allergies? If yes, list all:								
		-								
	Auth	norization								
I have reviewed the information on to to help determine appropriate and h	his questionnaire, and it is accurate to the realthful dental treatment. If there is any c	e best of my knowledge. I understand that hange in my medical status, I will inform	this information will be used by the dentist the dentist.							
I authorize the insurance compan I authorize the use of this signature	y indicated on this form to pay to the on all insurance submissions.	e dentist all insurance benefits otherwi	ise payable to me for services rendered.							
I authorize the dentist to release a whether or not paid by insurance.	ll information necessary to secure the p	payment of benefits. I understand that I	am financially responsible for all charges							
•		T) (27)								
F	Payment is due in full at time of treatment,	, unless prior arrangements have been ap	proved.							

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