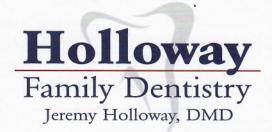
To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.



Patient Information (Confidential)

Name	Today's Date						
SS#/SIN	SINBirthdate				Home Phone		
Mailing Address	City		State	_ Zip			
Email		211-116	Cell Phone				
Check Appropriate box: Minor	Single Married	☐ Separated	Divorced	☐ Widow	ved		
If Student, Name of School/College	City		State	_ Full Time	Part Time		
Patient or Parent/Guardian's Employer			Work Phone				
Business Address	City		State	Zip			
Spouse or Parent/Guardian's Name	Employer		Work Phone				
Whom May We Thank for Referring You?							
Person to Contact In Case of Emergency			Phone				
Responsible Party							
Name of Person Responsible for this Account			Relationship to Patient				
Address							
			Cell Phone				
Employer	Work Phone			\$\$#/\$IN			
Is this Person Currently a Patient in our Office?	☐ Yes ☐ No						
Cash Personal Check Credit Ca Dental Insurance Information Name of Insured	rmation		Relationship to Patient				
BirthdateSS#							
Name of Employer							
Employer Address —				Zip			
Insurance Company							
Ins. Co. Address							
Ins. Co. Phone							
Do You Have Additional Dental Insurance?	☐ Yes ☐ No	If Yes, Complete the	e Following				
Name of Insured			Relationship to Patient				
Birthdate SS#	SS#/SIN			Date Employed			
Name of Employer	Union or Lo	ocal #	. Work Phone				
Employer Address ———————————————————————————————————	City		State	Zip			
Insurance Company	Group # _		Policy/ID #				
Ins. Co. Address	City		State	Zip			
Ins. Co. Phone							

Over Please

Physician		Office Phone			Date of Last Exam			
			Yes					Ye
. Are you under medical treatment now?				7. Do you use controlled substances?				
Have you ever been hospitalized for any surgical			_	8. Do you				
operation or serious illness within the last 5 years? If yes, please explain			9. Are you wearing contact lenses?					
			TOWNS TOWN		gic to or have you had any reactions	to the following	Ness Pin	
Ara you taking gov s	adicatio	un(a) including		V. 0.0.2.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0.			Aspirin	Г
 Are you taking any medication(s) including non-prescription medicine? 				Penicillin or any other Antibiotics 🔲 loding				
If yes, what medication	on(s) are	e you taking?			Drugs		atex Rubber	
-	V.60	#			iturate: atives	· · · · · · · · · · · · · · · · · · ·	Other ist:	
					77777	(e.g. nickel, mercury, etc.)	131.	
				11. Do vo	u have	a persistent cough or throat clearing	not	
1. Hava yay ayar takan	Econo	w Parius Astanal as any series		associ	ated w	ith an known illness (lasting more the	an 2 weeks)?	
4. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?		er 🗌	12. Wome	ACCOUNT OF THE PARTY AND				
		The state of the s	П	Are you pregnant or think you may be pregnant?				
Have you take Viagra, Revatio, Cialis or Levitra in the last 24 hours?			Are you nursing? Are you taking oral contraceptives?					
6. Do you have or have	you ha	d any of the following?		Ale.	you lui	ang ordi comracephives		_
High Blood Pressure		Heart Disease		Chest Pain		Heart Valve Replacement		
Heart Attack		Cardiac Pacemaker		Easily Winded		or Heart condition that requires		_
Rheumatic Fever		Heart Murmur		Stroke		you to take meds prior to exam		
Swollen Ankles		Angina		Hay Fever/Allergies		General Heart Concerns or Proce	edures	
Fainting/Seizures		Frequently Tired		Tuberculosis		(valve, surgeries, stents, birth de	fect & repairs)	
Asthma	•	Anemia		Radiation Therapy		General Lung Concerns		
Low Blood Pressure		Emphysema		Glaucoma		(Asthma, Infectious disease, end	locrine disease)	
Epilepsy/Convulsions		Cancer		Recent Weight Loss		Are you on blood thinners?		
Leukemia		Arthritis		Liver Disease		Other (Please List)		
Diabetes		Joint Replacement or Impla		Heart Trouble				
Kidney Diseases		Hepatitis		Respiratory Problems				
AIDS or HIV Infection		Sexually Transmitted Diseas Stomach Troubles/Ulcers		Mitral Valve Prolapse				
Thyroid Problem		Siomach froubles/ Oicers						
Patient Den	ital I	History						
Name of Previous De	entist ar	nd Location				Date of Last Exam		
			Yes				Yes	
1. Do your gums bleed while brushing or flossing?			8. Do you l	nave fre	equent headaches?			
2. Are your teeth sensitive to hot or cold liquids/foods?			9. Do you	clench	or grind your teeth?			
3. Are your teeth sensitive to sweet or sour liquids/foods?			10. Do you	bite yo	our lips or cheeks frequently?			
4. Do you feel any pain to any of your teeth?			11. Have y	11. Have you ever had any difficult extractions in the past?		ast?		
5. Do you have any sores or lumps in or near your mouth?			Account to the second		r had any prolonged bleeding			
6. Have you had any head, neck or jaw injuries?			followin	-		H		
7. Have you ever experienced any of the following					any orthodontic treatment?			
problems in your jaw	νŞ					dentures or partials?	ш	
Clicking				If yes, date of placement				
Pain (joint, ear, side of face)				15. Have you ever received oral hygiene instructions				
Difficulty in opening or closing Difficulty in chewing		H		regarding the care of your teeth and gums? 16. Do you like your smile?		i		
Division and the Control of the Cont				16. Do you	like yo	our smile?		
Authorization	er omnerense							
		erstand the above information to have been accurately answered.				to pay directly to the dentist or dental ç ole to me. I understand that my dental		
		ion can be dangerous to my heal				bill for services. I agree to be responsi		
dentist to release any inf	ormation	n including the diagnosis and the	records of an	y services rendered		behalf or my dependents.		
		ed to me or my child during the p and/or health practitioners. I autl						
				Signature of patien	t (or par	rent/guardian if minor)		
Doctor's Comm	nents _							
-	<u> </u>							-
			Signatu	re		Date		