## PATIENT INFORMATION

## CONFIDENTIAL

PATIENT	#	

(PLEASE PRINT)		
NAMEFIRST MI LAST	BIRTHDATE	HOME PHONE
ADDRESS		DIAIF/
E-MAIL		
CHECK APPROPRIATE BOX: MINOR SING	LE MARRIED DIVOR	CED WIDOWED SEPARATED
PARENT/GUARDIAN'S EMPLOYER  BUSINESS ADDRESS		
SPOUSE OR PARENT/GUARDIAN'S NAME	WORK PHONESTATE/	
IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLL	EGE	CITY PROV.
WHOM MAY WE THANK FOR REFERRING YOU?	A TOTAL SECTION AND A SECTION ASSECTION ASSECTION ASSECTION ASSECTION ASSECTION ASSECTION ASSECTION ASSECTION ASSECTION ASSECTIO	
PERSON TO CONTACT IN CASE OF AN EMERGENCY		PHONE
RESPONSIBLE PARTY		
NAME OF PERSON RESPONSIBLE FOR THIS ACCOU	UNT	RELATIONSHIPTO PATIENT
ADDRESS		
E-MAIL	CELI	L PHONE
DRIVER'S LICENSE # BIRTH		
EMPLOYER	WOR	RK PHONE
IS THIS PERSON CURRENTLY A PATIENT IN OUR OF	FFICE? YES	NO
INSURANCE INFORMATION		
NAME OF INSURED		RELATIONSHIP TO PATIENT
BIRTHDATE SS #/SIN _		
NAME OF EMPLOYER	WORK PHON	NE
NAME OF EMPLOYERADDRESS OF EMPLOYER	CITY	STATE/ ZIP/ PROV P.C
INSURANCE COMPANY		UNION OR LOCAL #
INS. CO. ADDRESS	CITY	STATE/ ZIP/ PROV P.C
HOW MUCH IS YOUR DEDUCTIBLE? HOW	MUCH HAVE YOU USED?	MAX. ANNUAL BENEFIT?
DO YOU HAVE ANY ADDITIONAL INSURANCE	E? NO IF Y	ES, COMPLETE THE FOLLOWING:
NAME OF INSURED		RELATIONSHIPTO PATIENT
BIRTHDATE SS #/SIN _		
NAME OF EMPLOYER	WORK PHON	NESTATE/ ZIP/
ADDRESS OF EMPLOYER		SIAIF!
INSURANCE COMPANY	GROUP #	UNION OR LOCAL #
INSURANCE COMPANYINS. CO. ADDRESS	CITY	PROV P.C
HOW MUCH IS YOUR DEDUCTIBLE? HOW	MUCH HAVE YOU USED?	MAX. ANNUAL BENEFIT?

**SIGNATURE** 

PATIENT NAME  HOME ADDRESS  DATE OF BIRTH  HOME PHONE  E-MAIL  BUSINESS ADDRESS  BUSINESS PHONE  SS #/SIN  PATIENT MEDICAL HISTORY  PINSICIAN  OFFICE PHONE  TES NO  ARE YOU LINDER NEDICAL HEATMENT NOW?  ARE YOU LINDER ON OFFICE NEDICAL HUNSS'  ARE YOU WEARNOOL CONTACT LENSES?  ARE YOU LINDER ON OFFICE NEDICAL HUNSS'  ARE YOU WEARNOOL SEALCHOOL, COCANNE OR OTHER DILLOWING?  YES NO  HIGH BIOOD PRESSURE   HARD DISEASE   HARD DILLOWING?  YES NO  HIGH BIOOD PRESSURE   HARD DISEASE   HARD DI					
HOME ADDRESS  DATE OF BIRTH  HOME PHONE  E-MAIL  BUSINESS ADDRESS  BUSINESS PHONE  SS #/SIN  PATIENT MEDICAL HISTORY  PRINCIPAN MEDICAL HEADMINT NOW?  1. ARE YOU UNDIR MEDICAL HEADMINT NOW?  2. INEX YOU EVER BEEN HOSPITALIZED FOR ANY 2. HOW YOU INTO BEEN HOSPITALIZED FOR ANY 3. ARE YOU INTO BEEN HOSPITALIZED FOR ANY 4. HOW YOU EVER KAREN IT TA-PREVAILED Y 4. HOW YOU INTO BEEN HOSPITALIZED FOR ANY 4. HOW YOU HAVE BEEN HOSPITALIZED FOR ANY 4. HOW YOU HAVE OR HAVE YOU HAD ANY OF HIS POLLOWING? 4. HOW YOU HAVE OR HAVE YOU HAD ANY OF HIS POLLOWING? 4. HOW YOU HAVE OR HAVE YOU HAD ANY OF HIS POLLOWING? 4. HOW YOU HAVE OR HOW YOU HAD ANY OF HIS POLLOWING? 4. HOW YOU HAVE OR HOW YOU HAD ANY OF HIS POLLOWING? 5. HOW HAVE AN AND YOU HAD ANY OF HIS POLLOWING? 5. HOW HAVE AN AND ANY HOW AND ANY HOW ANY HOW AND HOW	PATIENT NAME	TODAY'S DATE	P/		
PATIFINI MEDICAL HISTORY  PATIFINI MEDICAL HISTORY  OFFICE PHONE YES NO  1. ARE YOU LINDER MEDICAL TREAIMENT NOW?  2. HAVE YOU EVER BEEN ROSPITALIZED FOR ANY SURCICAL OPERATION OR SERVISION LINESS?  3. ARE YOU TAKING ANY MEDICALONS) INCLUDING NOW, PEBCCIPION MEDICINE?  15 YES, WHAT INEDICATION(S) ARE YOU TAKING?  9. DO YOU LASE ALCOHOL, COCAINE OR THER DIRLOST?  16. DO YOU LISE ALCOHOL, COCAINE OR OTHER DIRLOST?  17 SEN O YOU LASE ALCOHOL, COCAINE OR OTHER DIRLOST?  18 DO YOU LISE ALCOHOL, COCAINE OR OTHER DIRLOST?  19 DO YOU LASE ALCOHOL, COCAINE OR OTHER DIRLOST?  10 DO YOU LASE ALCOHOL, COCAINE OR OTHER DIRLOST?  11 LOO YOU LAND REPSESSURE   HEART TISES?  12 DO YOU LASE ALCOHOL, COCAINE OR DIRLOST   HEART TISES?  12 DO YOU LASE ALCOHOL, COCAINE OR OTHER DIRLOST?  13 ARE YOU PRECIANCE OR OTHER DIRLOST?  14 HEART TISES.  15 DO YOU LASE ALCOHOL, COCAINE OR OTHER DIRLOST?  16 DO YOU LASE ALCOHOL, COCAINE OR OTHER DIRLOST?  17 AME YOU WEARING, CONTACT LENSIES?  18 DO YOU LAND REPSESSURE   HEART TISES?  19 DO YOU LAND REPSESSURE   HEART TISES?  10 DO YOU LAND REPSESSURE   HEART TISES?  10 DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOIL OWING?  11 LOON BLOOD PRESSURE   HEART TISES?  12 DO YOU BUSE INFO WEARING OR SURVEY CONVELSIONS   COMMENTS  13 ARE YOU PRECIAN TO BE THE WEARING OR SURVEY CONVELSIONS   COMMENTS  14 DO YOU BLOOD PRESSURE   HEART TISES?  15 DO YOU BUSE TEST WILL BRUSHING OR BLOOD PRESSURE   MEMPISSANE   HEART TISES?  16 DO YOUR CLUSS BLITTO WHILE BRUSHING OR BLOOD PRESSURE   HEART TISES?  17 DO YOUR CLUSS BLITTO WHILE BRUSHING OR BLOOD PRESSURE   HEART TISES?  18 ARE YOU THE FOIL OWN TO FOLD IN TURBER   HEART TISES?  19 DO YOU LITER TO HOT OR COLD HOURSPROODS?  10 DO YOU BLITTO WHILE BRUSHING OR BLOOD PRESSURE   HEART TISES?  10 DO YOU BLITTO WHILE BRUSHING OR BLOOD PRESSURE   HEART TISES?  10 DO YOU BLITTO WHILE BRUSHING OR BLOOD PRESSURE   HEART TISES?  10 DO YOU BLITTO WHILE BRUSHING OR BLOOD PRESSURE   HEART TISES?  10 DO YOU BLITTO WHILE BRUSHING OR BLOOD PRESSURE   HEART TISES?  10 DO YOU BLITTO W					
PATIFINI MEDICAL HISTORY  PATIFINI MEDICAL HISTORY  OFFICE PHONE YES NO  1. ARE YOU LINDER MEDICAL TREAIMENT NOW?  2. HAVE YOU EVER BEEN ROSPITALIZED FOR ANY SURCICAL OPERATION OR SERVISION LINESS?  3. ARE YOU TAKING ANY MEDICALONS) INCLUDING NOW, PEBCCIPION MEDICINE?  15 YES, WHAT INEDICATION(S) ARE YOU TAKING?  9. DO YOU LASE ALCOHOL, COCAINE OR THER DIRLOST?  16. DO YOU LISE ALCOHOL, COCAINE OR OTHER DIRLOST?  17 SEN O YOU LASE ALCOHOL, COCAINE OR OTHER DIRLOST?  18 DO YOU LISE ALCOHOL, COCAINE OR OTHER DIRLOST?  19 DO YOU LASE ALCOHOL, COCAINE OR OTHER DIRLOST?  10 DO YOU LASE ALCOHOL, COCAINE OR OTHER DIRLOST?  11 LOO YOU LAND REPSESSURE   HEART TISES?  12 DO YOU LASE ALCOHOL, COCAINE OR DIRLOST   HEART TISES?  12 DO YOU LASE ALCOHOL, COCAINE OR OTHER DIRLOST?  13 ARE YOU PRECIANCE OR OTHER DIRLOST?  14 HEART TISES.  15 DO YOU LASE ALCOHOL, COCAINE OR OTHER DIRLOST?  16 DO YOU LASE ALCOHOL, COCAINE OR OTHER DIRLOST?  17 AME YOU WEARING, CONTACT LENSIES?  18 DO YOU LAND REPSESSURE   HEART TISES?  19 DO YOU LAND REPSESSURE   HEART TISES?  10 DO YOU LAND REPSESSURE   HEART TISES?  10 DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOIL OWING?  11 LOON BLOOD PRESSURE   HEART TISES?  12 DO YOU BUSE INFO WEARING OR SURVEY CONVELSIONS   COMMENTS  13 ARE YOU PRECIAN TO BE THE WEARING OR SURVEY CONVELSIONS   COMMENTS  14 DO YOU BLOOD PRESSURE   HEART TISES?  15 DO YOU BUSE TEST WILL BRUSHING OR BLOOD PRESSURE   MEMPISSANE   HEART TISES?  16 DO YOUR CLUSS BLITTO WHILE BRUSHING OR BLOOD PRESSURE   HEART TISES?  17 DO YOUR CLUSS BLITTO WHILE BRUSHING OR BLOOD PRESSURE   HEART TISES?  18 ARE YOU THE FOIL OWN TO FOLD IN TURBER   HEART TISES?  19 DO YOU LITER TO HOT OR COLD HOURSPROODS?  10 DO YOU BLITTO WHILE BRUSHING OR BLOOD PRESSURE   HEART TISES?  10 DO YOU BLITTO WHILE BRUSHING OR BLOOD PRESSURE   HEART TISES?  10 DO YOU BLITTO WHILE BRUSHING OR BLOOD PRESSURE   HEART TISES?  10 DO YOU BLITTO WHILE BRUSHING OR BLOOD PRESSURE   HEART TISES?  10 DO YOU BLITTO WHILE BRUSHING OR BLOOD PRESSURE   HEART TISES?  10 DO YOU BLITTO W					
PATIFINI MEDICAL HISTORY  PATIFINI MEDICAL HISTORY  OFFICE PHONE YES NO  1. ARE YOU LINDER MEDICAL TREAIMENT NOW?  2. HAVE YOU EVER BEEN ROSPITALIZED FOR ANY SURCICAL OPERATION OR SERVISION LINESS?  3. ARE YOU TAKING ANY MEDICALONS) INCLUDING NOW, PEBCCIPION MEDICINE?  15 YES, WHAT INEDICATION(S) ARE YOU TAKING?  9. DO YOU LASE ALCOHOL, COCAINE OR THER DIRLOST?  16. DO YOU LISE ALCOHOL, COCAINE OR OTHER DIRLOST?  17 SEN O YOU LASE ALCOHOL, COCAINE OR OTHER DIRLOST?  18 DO YOU LISE ALCOHOL, COCAINE OR OTHER DIRLOST?  19 DO YOU LASE ALCOHOL, COCAINE OR OTHER DIRLOST?  10 DO YOU LASE ALCOHOL, COCAINE OR OTHER DIRLOST?  11 LOO YOU LAND REPSESSURE   HEART TISES?  12 DO YOU LASE ALCOHOL, COCAINE OR DIRLOST   HEART TISES?  12 DO YOU LASE ALCOHOL, COCAINE OR OTHER DIRLOST?  13 ARE YOU PRECIANCE OR OTHER DIRLOST?  14 HEART TISES.  15 DO YOU LASE ALCOHOL, COCAINE OR OTHER DIRLOST?  16 DO YOU LASE ALCOHOL, COCAINE OR OTHER DIRLOST?  17 AME YOU WEARING, CONTACT LENSIES?  18 DO YOU LAND REPSESSURE   HEART TISES?  19 DO YOU LAND REPSESSURE   HEART TISES?  10 DO YOU LAND REPSESSURE   HEART TISES?  10 DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOIL OWING?  11 LOON BLOOD PRESSURE   HEART TISES?  12 DO YOU BUSE INFO WEARING OR SURVEY CONVELSIONS   COMMENTS  13 ARE YOU PRECIAN TO BE THE WEARING OR SURVEY CONVELSIONS   COMMENTS  14 DO YOU BLOOD PRESSURE   HEART TISES?  15 DO YOU BUSE TEST WILL BRUSHING OR BLOOD PRESSURE   MEMPISSANE   HEART TISES?  16 DO YOUR CLUSS BLITTO WHILE BRUSHING OR BLOOD PRESSURE   HEART TISES?  17 DO YOUR CLUSS BLITTO WHILE BRUSHING OR BLOOD PRESSURE   HEART TISES?  18 ARE YOU THE FOIL OWN TO FOLD IN TURBER   HEART TISES?  19 DO YOU LITER TO HOT OR COLD HOURSPROODS?  10 DO YOU BLITTO WHILE BRUSHING OR BLOOD PRESSURE   HEART TISES?  10 DO YOU BLITTO WHILE BRUSHING OR BLOOD PRESSURE   HEART TISES?  10 DO YOU BLITTO WHILE BRUSHING OR BLOOD PRESSURE   HEART TISES?  10 DO YOU BLITTO WHILE BRUSHING OR BLOOD PRESSURE   HEART TISES?  10 DO YOU BLITTO WHILE BRUSHING OR BLOOD PRESSURE   HEART TISES?  10 DO YOU BLITTO W	E-MAIL	CELL PHONE			
PATIENT MEDICAL HISTORY  PHYSICIAN OFFICE PHONE YES NO SARE YOU UNDER MEDICAL TREATMENT NOW? YES NO	BUSINESS ADDRESS				
PHYSICIAN OFFICE PHONE YES NO  1. ARE YOU LINDER MEDICAL TREATMENT NOW?					
PHYSICIAN					
1. ARE YOU LIDER MEDICAL IREATMENT NOW?  2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERROUS LILLYESS?  2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERROUS LILLYESS?  3. ARE YOU ALLONG OR SERROUS LILLYESS?  4. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERROUS LILLYESS?  5. ARE YOU ALLONG OR SERROUS LILLYESS?  6. LOCAL ANESTHETICS  6. DO YOU HAVE APPRISON OR SERROUS LILLYESS?  7. ARE YOU ALLONG OR OTHER DRUGS?  8. ARE YOU ALLONG OR OTHER DRUGS?  9. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOTE ASSOCIATED WITH A KNOWN ILLESS CLASTING MORE HIAN 3 WEEKS?  10. DO YOU USE TOBACCO?  11. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? YES NO  12. ARE YOU ALRONG DIVINE A PERSISTENT COUGH OR THROAT CLEARING NOTE ASSOCIATED WITH A KNOWN ILLESS CLASTING MORE HIAN 3 WEEKS?  13. ARE YOU ALRONG CONTACT LENSES?  14. AND ON USE ALCOHOL, COCAINE OR OTHER DRUGS?  15. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? YES NO  16. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? YES NO  17. ARE YOU WEARING CONTACT LENSES?  18. HEART ATTACK  19. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? YES NO  19. HIGH BLOOD PRESSURE  10. HEART ATTACK  10. DO YOU HAVE HORD ANY OF THE FOLLOWING? YES NO  10. SHOULEY ANALES  11. DO YOU BLOOD PRESSURE  11. DO YOU BLOOD PRESSURE  12. ARE YOU WELFORD ANY OF THE FOLLOWING HEART HAVE AND ANALY TRANSHIPTED DISEASE.  13. HAVE YOU EVER TRANSHIPT OF SWEED AND ANALY TRANSHIPTED DISEASE.  14. HAVE YOU EVER HAD ANY HEAD, NOT REPORTED AND ANALY TRANSHIPTED DISEASE.  15. DO YOU GLENCH OR GRIND YOUR TEETIN?  16. DO YOU GLENCH FOR OR HOW TO YOUR TEETIN?  17. HAVE YOU EVER HAD ANY HEAD AND THE HOLLOWING?  18. HAVE YOU EVER HAD BRISTICHION ON THE  19. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?  10. HAVE YOU EVER HAD ANY HEAD AND THE HOLLOWING?  10. HAVE YOU EVER HAD ANY HEAD AND THE HOLLOWING?  11. HAVE YOU EVER HAD ANY HEAD AND THE HOLLOWING?  12. HAVE YOU EVER HAD INSTRUCTIONS ON THE  14. HAVE YOU EVER HAD ANY HEAD AND THE HOL	PHYSICIAN				
2. HAY YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLUSSS?    ARE YOU TAKING ANY MEDICATION(S)	THIS IS A STATE OF THE STATE OF	YES NO			
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICLA DEPERATION SE DEPERATION OR DEPERA	ARE YOU UNDER MEDICAL TREATMENT NOW?		LLOWING?		
INCLUDING NON-PRESCRIPTION MEDICINE?  IF YES, WHAT MEDICATION(S) ARE YOU TAKING?  IF YES, WHAT MEDICATION(S) ARE YOU LAKING?  9. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING NORE THAN 3 WEEKS)?  ID OYOU USE IOBACCO?  ID OYOU USE IOBACCO?  ID OYOU USE ALCOHOL, COCAINE OR OTHER DRUGS?  7. ARE YOU WEARING CONTACT LENSES?  ID OYOU HAVE ARE YOU WEARING CONTACT LENSES?  ID OYOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?  YES NO    HIGH BLOOD PRESSURE   HEART MURRUR	2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	LOCAL ANESTHETICS   BARBITURATES   AS (E.G. NOVOCAINE)			
9. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)?  10. WOMEN OALY: A RE YOU WEARING CONTACT LENSES? 10. OVOU USE IOBACCO? 10. WOMEN OALY: A RE YOU WEARING CONTACT LENSES? 11. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? YES NO YES NO YES NO HEART DISEASE CARDIAC PACEMAKER RIFLUMATIC FEVER RIFLUMATIC REVER	3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	ANTIBIOTICS	HER		
4. HAVE YOU EVER TAKEN FEN-PHEN/REDUX?  5. DO YOU USE TOBACCO?  6. DO YOU USE TOBACCO?  7. ARE YOU WEARING CONTACT LENSES?  8. DO YOU HAVE A PERSISTENT COUGH OR THIROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEFKS)?  9. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS?  10. WOMEN ONLY.  11. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?  YES NO  12. ARE YOU WEARING CONTACT LENSES?  13. ARE YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?  YES NO  14. HEART ATTACK  15. HEART ATTACK  16. HEART ATTACK  17. ARE HEART ATTACK  17. ARE HEART ATTACK  18. SWOLLEN ANNES  19. HEART DISEASE  19. HEART DISEASE  19. HEART DISEASE  19. HEART MURBUR  19. HEART MURBUR  19. HEREOLUCITY HIRED  19. ARE YOU BLOOD PRESSURE  19. HEART MURBUR  19. HEREOLUCITY HIRED  19. ARE HEART ROUBLE  19. HEART HOUSE  10. HEREOLUCITY HERE	IF YES, WHAT MEDICATION(S) ARE YOU TAKING?		NO		
ILLNESS (LASTING MORE THAN 3 WEEKS)?	4. HAVE YOU EVER TAKEN FEN-PHEN/REDUX?	9. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN	NO		
A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?		ILLNESS (LASTING MORE THAN 3 WEEKS)?			
7. ARE YOU WEARING CONTACT LENSES?    C) ARE YOU TAKING BIRTH CONTROL PILLS?    D YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?  YES NO   HIGH BLOOD PRESSURE   HEART DISEASE   EASILY WINDED   HEART ATTACK   HEART MINENUM   HEART MURNUM   STROKE   HEART MURNUM   HEART MURNUM   HEART MURNUM   HEART MURNUM   HEART MURNUM   HEART MURNUM   HAY FEVER / ALLERGIES   HAY	6. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS:	A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?			
II. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?  YES NO  HEART DISEASE  HEART ATTACK  HEART ATTACK  HEART ATTACK  HEART MURMUR  HEART TROUBLE  TROUBLESASE  HEART TROUBLE  HEART TROUBLE  HEART TROUBLE  HAY FEVER / ALLERGIES  HAY EVER HEART MURMUR  HAY FEVER / ALLERGIES  HAY EVER HAD PROLONGED BLEEDING  FOLLOWING EXTRACTIONS  HIT HE MAST  HAY EVOU EVER HAD INSTRUCTIONS ON THE  HEART TROUBLE  HAY EVOU EVER HAD INSTRUCTIONS ON THE  HEART TROUBLE  HEART TROUBLE  HAY EVER HEART TROUBLE  HEART TROUBLE  HEART TROUBLE  HEART T	7. ARE YOU WEARING CONTACT LENSES?	C) ARE VOIL TAVING PIRTH CONTROL TO THE			
YES NO  1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?  2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?  3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?  4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?  5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?  6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?  7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?  A) CLICKING?  B) PAIN (JOINT, EAR, SIDE OF FACE)?  C) DIFFICULTY IN OPENING OR CLOSING?  D) DIFFICULTY IN CHEWING?  NO  8. DO YOU HAVE FREQUENT HEADACHES?  9. DO YOU HAVE FREQUENT HEADACHES?  10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?  11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?  12. HAVE YOU HAD ANY ORTHODONTIC WORK?  13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?  14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?  15. HAVE YOU EVER HAD INSTRUCTIONS ON THE	YES NO  HIGH BLOOD PRESSURE HEART DI CARDIAC RHEUMATIC FEVER SWOLLEN ANKLES ANGINA FAINTING / SEIZURES FREQUEN ASTHMA LOW BLOOD PRESSURE FILEPSY / CONVULSIONS CANCER EPILEPSY / CONVULSIONS CANCER LEUKEMIA DIABETES DIABETES DIABETES AIDS OR HIV INFECTION SEXUALLY	YES NO  ISEASE  CHEST PAINS  PACEMAKER  STROKE  HAY FEVER / ALLERGIES  TUBERCULOSIS  RADIATION THERAPY  GLAUCOMA  GLAUCOMA  RECENT WEIGHT LOSS  LIVER DISEASE  PLACEMENT OR IMPLANT  (TRANSMITTED DISEASE  TOTHER  OTHER  O			
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?  2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?  3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?  4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?  5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?  6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?  7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?  A) CLICKING?  B) PAIN (JOINT, EAR, SIDE OF FACE)?  C) DIFFICULTY IN OPENING OR CLOSING?  D) DIFFICULTY IN CHEWING?  8. DO YOU HAVE FREQUENT HEADACHES?  9. DO YOU CLENCH OR GRIND YOUR TEETH?  10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?  11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?  12. HAVE YOU HAD ANY ORTHODONTIC WORK?  13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?  14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?  15. HAVE YOU EVER HAD INSTRUCTIONS ON THE		PATIENT DENTAL HISTORY			
CADE OF VOLID CHARGO	<ol> <li>ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQU</li> <li>ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQU</li> <li>DO YOU FEEL PAIN TO ANY OF YOUR TEETH?</li> <li>DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOU</li> <li>HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?</li> <li>HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOW PROBLEMS IN YOUR JAW?         <ul> <li>A) CLICKING?</li> <li>B) PAIN (JOINT, EAR, SIDE OF FACE)?</li> <li>C) DIFFICULTY IN OPENING OR CLOSIN</li> </ul> </li> </ol>	8. DO YOU HAVE FREQUENT HEADACHES?  9. DO YOU CLENCH OR GRIND YOUR TEETH?  10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?  11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?  12. HAVE YOU HAD ANY ORTHODONTIC WORK?  13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?  14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?  15. HAVE YOU EVER HAD INSTRUCTIONS ON THE			

SIGNATURE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

X

PATIENT, PARENT OR GUARDIAN

DATE