## 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

| Cell Phone Email Subscriber Employ:   by Business Phone Business Email Insurance Compan, Phone Insurance Email                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         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| Have you ever experienced an<br>Other information about your de                                                 | n adverse reaction during or in conental health or previous treatment           | njunction with a medical or denta                                                                               | fi btoceonius a a a u                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
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| If yes, describe                                                                                                |                                                                                 |                                                                                                                 | <u>4</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Are you currently under physicia                                                                                | an care? 🗀 Y 🗓 N If yes, des                                                    | cribe                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Have you ever had a blood tran-                                                                                 | sfusion? 🗀 Y 🗆 N If yeş, give                                                   | approximate dates                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Women: Are you pregnant?                                                                                        | Y LIN Nursing? LIY LIN                                                          | Taking birth control pills? DY                                                                                  | UN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| ,                                                                                                               |                                                                                 |                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| م معالم المعالم | usu baya had any of the following:                                              |                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                 | you have had any of the following:                                              |                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| □ Y □ N AIDS/HIV Positive                                                                                       |                                                                                 | ☐ Y ☐ N Jaw pain                                                                                                | ☐ Y ☐ N 1 lingles.<br>☐ Y ☐ N 1 lortness of breath                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| □Y □ N Anaphylaxis                                                                                              | ☐ Y ☐ N Cough up blood                                                          | ☐ Y ☐ N Kidney disease or malfunction                                                                           | ☐Y ☐ N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| □Y□N Anemia                                                                                                     | UYUN Diabetes<br>UYUN Epilepsy                                                  | ☐Y ☐ N Liver disease                                                                                            | □Y□N i jina Bifida                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| ☐ Y ☐ N: Arthritis, Rheumatism<br>☐ Y ☐ N: Artificial heart valves                                              | LY CN Fainting                                                                  | □ Y □ N Material allergles                                                                                      | DY UN roke                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| ☐ Y ☐ N Artificial joints                                                                                       | ☐Y ☐ N Food allergies                                                           | (latex, wool, metal,                                                                                            | □Y □ N : irgical implant                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| UYUN Asthma                                                                                                     | □Y□N Glaucoma                                                                   | chemicals)                                                                                                      | □ Y □ N → velling of feet                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| UY □ N Atopic (allergy prone)                                                                                   |                                                                                 | UY UN Nervous problems                                                                                          | ı ı ankleş                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| □Y □ N Back problems                                                                                            | ☐ Y ☐ N Heart murmur                                                            | UY DN Pacemaker/                                                                                                | ☐ Y ☐ N iyroid disease or alfunction                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                                                                 | ☐ Y ☐ N Heart problems                                                          | Heart surgery                                                                                                   | □Y □ N i bacco habit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| ÜY □ N Cancer                                                                                                   | Describe                                                                        | □ Y □ N Psychiatric care                                                                                        | DY DN insillitis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| □ Y □ N Chemical dependency                                                                                     | ☐ Y ☐ N Hemophilia/<br>Abnormal bleeding                                        |                                                                                                                 | □Y □N inberculosis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| ☐ Y ☐ N Chemotherapy                                                                                            | DV DN Hernes                                                                    | □ Y Q N Radiation treatment                                                                                     | □Y □N   cer/Colitis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| □ Y □ N Circulatory problems                                                                                    | □Y UN Hepatitis                                                                 | ⊔ Y ဩ N Respiratory disease                                                                                     | UY DN 'mereal disease                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| ☐ Y ☐ N Cortisone treatments                                                                                    | ☐Y ☐ N High blood pressure                                                      | □ Y □ N Rheumatic/Scarlet fever                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Is patient currently taking any m                                                                               | nedications? If yes, list all:                                                  | Does patient have drug allergies                                                                                | s? If yes, list rdl:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                                                                 |                                                                                 |                                                                                                                 | . 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| · · · · · · · · · · · · · · · · · · ·                                                                           |                                                                                 |                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| · .                                                                                                             | <b>ATTTTOR</b>                                                                  | IZATION                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                 | AU 1 HOL                                                                        | IZALION                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| I have reviewed the information will be used by the dentist to help the dentist.                                | on this questionnaire, and it is acc<br>determine appropriate and healthful     | urate to the best of my knowledge.<br>dental treatment. If there is any chan                                    | . I understar ; that this informatio<br>ige in my me I cal status,I will inform                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| I authorize the insurance compa                                                                                 | any indicated on this form to pay to t<br>his signature on all insurance submis | ne dentist all insurance benefits ott<br>sions.                                                                 | nerwise pay;   le to me for service                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| I authorize the dentist to relea                                                                                | ase all information necessary to s<br>er or not paid by insurance. If turned    | ecure the payment of benefits. I                                                                                | understand hat I am financial<br>is responsible for all collection cos                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| _                                                                                                               |                                                                                 |                                                                                                                 | Dete                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Signature                                                                                                       |                                                                                 |                                                                                                                 | Date                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |

## Patient Consent & Authorization for Release of Protected Health Information

| Please Print                                                                    |                                     |                                             |                                         |
|---------------------------------------------------------------------------------|-------------------------------------|---------------------------------------------|-----------------------------------------|
| Patient Name:                                                                   |                                     |                                             | Date of Birth:                          |
| Address:                                                                        |                                     |                                             |                                         |
| City:                                                                           | State: ZIP Cod                      | le: Telephone N                             | umber:                                  |
| E-mail Address:                                                                 |                                     |                                             |                                         |
|                                                                                 |                                     |                                             |                                         |
| Patient Authorization                                                           |                                     |                                             |                                         |
| l,                                                                              | , hereby authorize th               | ne release, use or disclosure of my         | health information as follows:          |
| This authorization per ains to the f                                            |                                     |                                             |                                         |
|                                                                                 |                                     |                                             |                                         |
|                                                                                 |                                     |                                             | ,                                       |
|                                                                                 |                                     | a ; ****                                    | 1111                                    |
| I hereby authorize                                                              | Name of individual(s) an            | d/or organization providing information     | A 6.7                                   |
| to release the above-described infor                                            | mation to                           |                                             |                                         |
| I understand that, per upy request, th                                          | Name of                             | individual(s) and/or organization receiving | ng this information                     |
| information for purposes beyond tre                                             | atment, payment, or healthcare o    |                                             |                                         |
| and Accountability Act of 1996 (HIP                                             |                                     | 11                                          |                                         |
| I understand that I may revoke this a                                           |                                     |                                             |                                         |
|                                                                                 |                                     |                                             |                                         |
| The revocation will be affective on the revocation does not apply to actions to |                                     |                                             |                                         |
| that I do not have to sign this author                                          |                                     |                                             |                                         |
| Unless I request in writing otherwise                                           | , I understand that this authorizat | tion will expire on                         |                                         |
| specify an expiration die or event, th                                          | nis authorization will expire ninet | y (90) days from the date on which          | h I signed this authorization.          |
| I understand that the it formation us                                           | ed or disclosed pursuant to this a  | authorization may be subject to rec         | disclosure by the named                 |
| recipient, and may no imger be prote                                            | ected by HIPAA's privacy rules aft  | ter the authorized disclosure.              | ,                                       |
|                                                                                 |                                     |                                             |                                         |
| Patient or Person: Represe                                                      | ntative                             |                                             |                                         |
| C:                                                                              |                                     |                                             | Y2 / /                                  |
| Signature:                                                                      |                                     |                                             | Date://                                 |
| Name:Please Print                                                               |                                     |                                             | .,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |
| Relationship to Patient:                                                        |                                     |                                             |                                         |
|                                                                                 |                                     |                                             |                                         |
| For Office Use Only                                                             |                                     |                                             | )                                       |
| Received by:                                                                    |                                     |                                             | Date://                                 |
|                                                                                 |                                     |                                             |                                         |



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