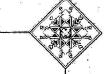


Welcome



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.

Parlent Information

Name				Soc. Sec. #	
Last Name	First Name	Ini	tial		
Address					
City				Home Phone	
Cell Phone					
Sex □ M □ F Age					
Patient Employed by		(=)		-	
Business Address					
Business Email					
Whom may we thank for referring you?					
Notify in case of emergency		Home Pho	ne		
	Business Phone				
Email					
		lon 0 17			_
	<u> </u>	macy lasora	ice .		
Person Responsible for Account					
	Last Name			First Name	Initial
Relation to Patient	Birthdate			Soc. Sec. #	
Address (if different from patient)					
City					
Cell Phone					
Person Responsible Employed by					
Business Address					
Business Email				Duamesa i none	
				nl	-
Insurance Company				Phone	
Insurance Email					N .
Contract #				Subscriber #	
Name of other dependents under this pla	Λ				
	-, Add	liforel Jasons	mae		
To pottont povound by additional to					
Is patient covered by additional insurance					
				Birthdate	
Address (if different from patient)			Soc. Sec.	#	
City	, State	Zip		Home Phone	
Cell Phone		. <u> </u>		Email	
Subscriber Employed by					
Business Email					
Insurance Company				Phone	
Insurance Email					
Contract #	Group #			Subscriber #	
Name of other dependents under this pla				500 VIII VIII VIII VIII VIII VIII VIII V	8

Please complete both sides.



Denial Bistory

What would you like us to do today?		Are you in dental discomfort today?					
Former Dentist	Address						
Dentist's Email	Phone						
Check (✓) yes or no if you have had		,					
The state of the s	☐ Y ☐ N Food collection between teeth	☐ Y ☐ N Periodontal treatment	☐ Y ☐ N Sensitivity to sweets				
D1 153 15350 HEROSCHOOL	☐ Y ☐ N Grinding or clenching teeth	☐ Y ☐ N Sensitivity to cold	☐ Y ☐ N Sensitivity when biting				
	☐ Y ☐ N Loose teeth or broken fillings	☐ Y ☐ N Sensitivity to hot	☐ Y ☐ N Sores or growths in mouth				
100 Ct. (1000)	0	•					
	of your teeth?						
10 10 10 10 10 10 10 10 10 10 10 10 10 1	se reaction during or in conjunction wi						
	ealth or previous treatment						
onici mormani about jour deniai n	cam or provious a cament						
Medical History							
		lnesses or operations? 🗆 Y 🗅 N					
If yes, describe		150					
Have you ever had a blood transfusion?							
Have you ever taken Fen-Phen/Redux?							
	medication? Brand names include Fosam		ra. 🗆 Y 🗔 N				
	N Nursing? 🗆 Y 🗅 N Taking bir	h control pills? 🗆 Y 🗀 N					
Check (🗸) yes or no whether you ha							
Y N AIDS/HIV Positive	☐ Y ☐ N Cough, persistent	□ Y □ N Jaw pain	□ Y □ N Shingles				
☐ Y ☐ N Anaphylaxis ☐ Y ☐ N Anemia	☐ Y ☐ N Cough up blood	☐ Y ☐ N Kidney disease or malfunction	☐ Y ☐ N Shortness of breath				
☐ Y ☐ N Arthritis, Rheumatism	☐ Y ☐ N Diabetes ☐ Y ☐ N Epilepsy	☐ Y ☐ N Liver disease	□ Y □ N Skin rash □ Y □ N Spina Bifida				
☐ Y ☐ N Artificial heart valves	☐ Y ☐ N Fainting	☐ Y ☐ N Material allergies	☐ Y ☐ N Stroke				
☐ Y ☐ N Artificial joints	☐ Y ☐ N Food allergies	(latex, wool, metal, chemicals)	☐ Y ☐ N Surgical implant				
□ Y □ N Astlima	☐ Y ☐ N Glaucoma	☐ Y ☐ N Mitral valve prolapse	☐ Y ☐ N Swelling of feet				
☐ Y ☐ N Atopic (allergy prone)	Y N Headaches	☐ Y ☐ N Nervous problems	or ankles				
☐ Y ☐ N Back problems ☐ Y ☐ N Blood disease	Y N Heart murmur	☐ Y ☐ N Pacemaker/	☐ Y ☐ N Thyroid disease or malfunction				
Y IN Blood disease	☐ Y ☐ N Heart problems Describe	Heart surgery	☐ Y ☐ N Tobacco habit				
☐ Y ☐ N Chemical dependency	□ Y □ N Hemophilia/	☐ Y ☐ N Psychiatric care	□ Y □ N Tonsillitis				
☐ Y ☐ N Chemotherapy	Abnormal bleeding	☐ Y ☐ N Rapid weight gain or loss ☐ Y ☐ N Radiation treatment	☐ Y ☐ N Tuberculosis				
☐ Y ☐ N Circulatory problems	□ Y □ N Herpes	☐ Y ☐ N Respiratory disease	☐ Y ☐ N Ulcer/Colitis				
☐ Y ☐ N Cortisone treatments	☐ Y ☐ N Hepatitis ☐ Y ☐ N High blood pressure	☐ Y ☐ N Rheumatic/Scarlet fever	☐ Y ☐ N Venereal disease				
Is patient currently taking any medicati		Does patient have drug allergies? If y	ves, list all:				
	Antho	ofization + > .					
I have reviewed the information on this to help determine appropriate and hea	s questionnaire, and it is accurate to the l althful dental treatment. If there is any ch	pest of my knowledge. I understand that ange in my medical status, I will inform	this information will be used by the dentist the dentist.				
	indicated on this form to pay to the		ise payable to me for services rendered.				
I authorize the dentist to release all whether or not paid by insurance.	information necessary to secure the pa	yment of benefits. I understand that I	am financially responsible for all charges				
Signature		Date					
-	yment is due in full at time of treatment, i	2.00					