WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name			Soc. Sec. #	
Last Name	First Name	Initial		
Address	State	Zin	Homo Phono	
Cell Phone				
Sex I M I F Age Birthda				
Patient Employed by				
Business Address				
Business Email				
Whom may we thank for referring you?				
Notify in case of emergency				
	Il Phone Business Pho			
Email				
Person Responsible for Account		RY INSUR	ANCE	
erson nesponsible 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				
Insurance Company				
Insurance Email				
Contract #				
Name of other dependents under this plan	ADDITIO	NAL INSU		
Is patient covered by additional insurance?		o Patient	Diathalasa	
Subscriber Name			Birthdate _	
			Soc. Sec. #	
City				
Cell Phone				
Subscriber Employed by				
Business Email				
Insurance Company				
Insurance Email				
Contract #				
Name of other dependents under this plan				

Please complete both sides.

DENTAL HISTORY

		HIOIOIII			
		100	Are you in dental discomfort today?		
		3			
	Phone				
		Date of last x-rays			
AL ADMINISTRATION OF THE PROPERTY OF THE PROPE	e had problems with any of the fo				
□Y □ N Bleeding gums	□ Y□ N Food collection between teeth□ Y□ N Grinding or clenching teeth	☐ Y ☐ N Sensitivity to cold	☐ Y ☐ N Sensitivity when biting		
☐ Y ☐ N Clicking or popping jaw	☐ Y ☐ N Loose teeth or broken fillings	□ Y □ N Sensitivity to hot	☐ Y ☐ N Sores or growths in mou		
How often do you brush?		Floss?			
PORTER TO THE PROPERTY OF THE	00.000 \$40.400 A 7500 C \$40.000 € 0.0				
Have you ever experienced an	adverse reaction during or in co	onjunction with a medical or denta	al procedure? □Y □N		
Other information about your de	ntal health or previous treatment_				
	MEDICAL	YMOTSIH .			
Physician's name		Phone			
Date of last visit	Have you had any	serious illnesses or operations?	UY UN		
		,			
Are you currently under physicia	an care? □Y □N If yes, des	scribe			
Have you ever had a blood trans		e approximate dates			
Have you ever taken Fen-Phen/		, 1			
		include Fosamax, Actonel, Atelvia, D	idronel and Boniva. Y N		
	Y D N Nursing? DY DN	Taking birth control pills? □ Y			
	ou have had any of the following:	Taking birtir control pine.			
☐Y☐N AIDS/HIV Positive	☐ Y ☐ N Cough, persistent	□Y □N Jaw pain	□ Y □ N Shingles		
☐Y ☐ N Anaphylaxis	☐ Y ☐ N Cough up blood	☐ Y ☐ N Kidney disease or	☐ Y ☐ N Shortness of breath		
□Y □N Anemia	☐Y ☐N Diabetes	malfunction	□ Y □ N Skin rash		
□ Y □ N Arthritis, Rheumatism	□Y □N Epilepsy	☐Y ☐N Liver disease	□ Y □ N Spina Bifida		
☐ Y ☐ N Artificial heart valves	Y N Fainting	☐ Y ☐ N Material allergies (latex, wool, metal,	☐ Y ☐ N Stroke		
□ Y □ N Artificial joints □ Y □ N Asthma	☐ Y ☐ N Food allergies ☐ Y ☐ N Glaucoma	chemicals)	☐ Y ☐ N Surgical implant ☐ Y ☐ N Swelling of feet		
☐ Y ☐ N Atopic (allergy prone)	□Y □N Headaches	☐ Y ☐ N Mitral valve prolapse ☐ Y ☐ N Nervous problems	or ankles		
□Y □ N Back problems	□ Y □ N Heart murmur	☐ Y ☐ N Pacemaker/	☐ Y ☐ N Thyroid disease or		
☐ Y ☐ N Blood disease	☐ Y ☐ N Heart problems	Heart surgery	malfunction ☐ Y ☐ N Tobacco habit		
□Y□N Cancer	Describe	☐ Y ☐ N Psychiatric care	☐ Y ☐ N Tonsillitis		
□ Y □ N Chemical dependency □ Y □ N Chemotherapy	Abnormal bleeding	☐ Y ☐ N Rapid weight gain or loss	☐ Y ☐ N Tuberculosis		
□ Y □ N Circulatory problems	□Y □N Herpes	□ Y □ N Radiation treatment□ 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		
s patient currently taking any m		Does patient have drug allergie	c2 If you list all:		
s patient currently taking any m	edications? If yes, list all.	Does patient have drug allergie.	s: II yes, list all.		
	ATTTIOF	RIZATION			
	AU I HUI	IIZAIION			
		curate to the best of my knowledge dental treatment. If there is any char			
I authorize the insurance compa	ny indicated on this form to pay to is signature on all insurance submis	the dentist all insurance benefits ot ssions.	herwise payable to me for service		
I authorize the dentist to releatesponsible for all charges whether		secure the payment of benefits. I	understand that I am financial		
Signature			Date		
22 7 20		unless prior arrangements have bee			