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		SC 3002 4004	Soc. Sec. #	
Last Name First Name		Initial		
Address				
City				
Cell Phone				
Sex DM DF Age Birthdate				
Patient Employed by				
Business Address				
Business Email				
Whom may we thank for referring you?				
Notify in case of emergency				
Cell Phone			one	
Email				
	PRIMA	RY INSUR	ANCE	
Person Responsible for Account				
erson responsible for Account	Last Name		First Name	Initial
Relation to Patient	Birthdate		Soc. Sec. #	
Address (if different from patient)				
City				
political param		Olale		
Person Responsible Employed by Business Address			Business Phone	
			Dusiliess Filolie	
Business Email			Dhono	
Insurance Company		1.00	Phone	
Insurance Email				
Contract #				
Name of other dependents under this plan _				
	ADDITIO:	NAL INSUI	MANCE	
s, patient covered by additional insurance?	☐ Yes ☐ No			
Subscriber Name	Relation to	Patient	Birthdate	
Address (if different from patient)			Soc. Sec. #	
City				
Cell Phone				
Subscriber Employed by				
Business Email				
Insurance Company				
Insurance Company			FIIOHE	
Contract #			0 1 1 "	

Please complete both sides.

DENTAL HISTORY

Former Dentist	Address	3					
	Phone _						
Check (✓) yes or no if you hav	e had problems with any of the fo	llowing:					
	□ Y □ N Food collection between teeth		Periodontal treatment	UYUNS	ensitivity to sweets		
	☐ Y ☐ N Grinding or clenching teeth				ensitivity when biting		
☐ Y ☐ N Clicking or popping jaw	☐ Y ☐ N Loose teeth or broken fillings		Sensitivity to hot	DYDNS	ores or growths in mou		
Charles and the control of the contr			Floss?				
	arance of your teeth?						
	adverse reaction during or in co			al procedu	re? □Y □N		
Other information about your de	ntal health or previous treatment_						
	MEDICAL	OTSIH L	RY				
Physician's name			Phone				
	Have you had any			OY ON			
If yes, describe							
Are you currently under physicia	an care? QY QN If yes, de	scribe					
Have you ever had a blood trans			ate dates				
Have you ever taken Fen-Phen/							
Have you ever used a bisphospl	honate medication? Brand names	include Fosa	amax, Actonel, Atelvia, D	idronel and	Boniva. DY DN		
	Y DN Nursing? DY DN		irth control pills?				
	ou have had any of the following:	3					
Y N AIDS/HIV Positive		DYDN	Jaw pain		Shingles		
☐Y ☐N Anaphylaxis	Y N Cough up blood		Kidney disease or		Shortness of breath		
□Y □ N Anemia	□Y□N Diabetes		malfunction		Skin rash		
☐ Y ☐ N Arthritis, Rheumatism	☐ Y ☐ N Epilepsy		Liver disease	\Box Y \Box N	Spina Bifida		
☐ Y ☐ N Artificial heart valves	☐ Y ☐ N Fainting	OYON	Material allergies (latex, wool, metal,	DYDN	Stroke		
Y N Artificial joints	□ Y □ N Food allergies		chemicals)		Surgical implant		
□Y □N Asthma	☐ Y ☐ N Glaucoma	DYDN	Mitral valve prolapse	DYDN	Swelling of feet or ankles		
☐Y ☐ N Atopic (allergy prone)		DYDN	Nervous problems		Thyroid disease or		
□Y □N Back problems	Y N Heart murmur	OY ON	Pacemaker/	3 T 3 N	malfunction		
Y N Blood disease	☐ Y ☐ N Heart problems Describe		Heart surgery	DYDN	Tobacco habit		
☐ Y ☐ N Cancer ☐ Y ☐ N Chemical dependency	☐ Y ☐ N Hemophilia/		Psychiatric care	OYON	Tonsillitis		
Y N Chemotherapy	Abnormal bleeding		Rapid weight gain or loss Radiation treatment	\square Y \square N	Tuberculosis		
☐ Y ☐ N Circulatory problems	□Y □N Herpes		Respiratory disease		Ulcer/Colitis		
☐ Y ☐ N Cortisone treatments	☐ Y ☐ N Hepatitis		Rheumatic/Scarlet fever	□Y □ N	Venereal disease		
e nationt currently taking any m	tly taking any medications? If yes, list all: Does patient have drug allergies? If yes, list all:						
5 patient ourrently taking any m	edications: If you, list all.	Docs pa	nont have arag anergie	o. 11 you, 11	or an.		
		-					
	AUTHOI	RIZATIO)N				
	AV I HVI	IILITII	-1				
	on this questionnaire, and it is acc determine appropriate and healthful		,				
authorize the insurance compar	ny indicated on this form to pay to is signature on all insurance submis		all insurance benefits ot	herwise pay	vable to me for service		
authorize the dentist to relea responsible for all charges whether	se all information necessary to error not paid by insurance.	secure the	payment of benefits. I	understan	d that I am financial		
Signature				Dat	e		