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	First Name	Initial	Soc. Sec. #	
Address	i iist ivaille	ninal		
City	State	Zip	Home Phone	THE WATER
Cell Phone				
Sex DM DF AgeBirthda			Married Widowed Separa	ted Divorced
Patient Employed by				
			Business Phone	
Business Email		4.7.5		
Whom may we thank for referring you?				
Notify in case of emergency		Home Phone		
Cell Phone		Business Ph	one	والمتعالب والمراج
Email				
	PRIMA	RY INSURA	INCE	
Person Responsible for Account	Last Name		First Name	Initial
				Commence of the Party of the Pa
아들이 아내가 있다. 이 나이에요 그들은 생각이 있는데 그는 그리고 이 이 그 그 그릇이 모든데 그 그 그 사람들이)		
Address (if different from patient)				
City				
Cell Phone				
Person Responsible Employed by	A		Occupation	
Business Address				
Business Email				
Insurance Company			Phone	
nsurance Email				
Contract #	Group #_		Subscriber #	
Name of other dependents under this plan		X-		
	ADDITIO	NAL INSUE	ANCE	
s patient covered by additional insurance?	Yes No			
Subscriber Name	Relation t	o Patient	Birthdat	e
Address (if different from patient)			Soc. Sec. #	
City	State	Zip	Home Phone	
Cell Phone			Email	
Subscriber Employed by	3	2.4	Business Phone	
Business Email				
Insurance Company		- I to the contract of the con	Phone	
Insurance Email		4. 4.54	HIM - TANKENSKA	
Contract #	Group #		Subscriber #	

DENTAL HISTORY

Y N Scres or growths in mother how often do you brush?			Are you in dental discomfort today?		
Dentist Semail	Former Dentist	Address_			
Check (/) yes or no if you have had problems with any of the following: Y N Bad breath	Dentist's Email	Phone			
Check (/) yes or no if you have had problems with any of the following: Y N Bad breath	Date of last dental care		Date of last x-rays		
Y N Glicking or popping jaw Y N Lose teeth or broken fillings Y N Sensitivity to hot Y N Sores or growths in mx N N N N N N N N N	Check (✓) yes or no if you have	ve had problems with any of the follower	owing:		
How do you feel about the appearance of your teeth? Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?	☐ Y ☐ N Bleeding gums ☐ Y ☐ N Clicking or popping jaw	☐ Y ☐ N Grinding or clenching teeth ☐ Y ☐ N Loose teeth or broken fillings	□ Y □ N Sensitivity to cold □ Y □ N Sensitivity to hot	☐ Y ☐ N Sensitivity when biting ☐ Y ☐ N Sores or growths in mouth	
Other information about your dental health or previous treatment. MEDICAL HISTORY					
Other information about your dental health or previous treatment. MEDICAL HISTORY					
Physician's name					
Are you currently under physician care? Y N If yes, describe	Physician's name	MEDICAL	HISTORY Phone		
Are you currently under physician care?	Date of last visit	Have you had any	serious illnesses or operations?	OY ON	
Have you ever had a blood transfusion? Y N If yes, give approximate dates Have you ever taken Fen-Phen/Redux? Y N Women: Are you pregnant? Y N Nursing? Y N Check (\forall) yes or no whether you have had any of the following:	If yes, describe	2			
Have you ever had a blood transfusion? Y N If yes, give approximate dates Have you ever taken Fen-Phen/Redux? Y N Women: Are you pregnant? Y N Nursing? Y N Check (\forall) yes or no whether you have had any of the following:	Are you currently under physicia	an care? DY DN If yes, desc	oribe		
Have you ever taken Fen-Phen/Redux?		sfusion? DY DN If yes, give	approximate dates		
Check (/) yes or no whether you have had any of the following: 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 malfunction Y N Shingles Y N Arthritis, Rheumatism Y N Diabetes Y N Arthritis, Rheumatism Y N Epilepsy Y N Material allergies (latex, wool, metal, chemicals) Y N Stroke (latex, wool, metal, chemi					
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Y N Anaphylaxis Y N Cough up blood Y N Kidney disease or malfunction Y N Shortness of breath malfunction Y N Skin rash Y N Spina Bifida Y N Spina Bifida Y N Spina Bifida Y N Artificial heart valves Y N Fainting Y N Artificial heart valves Y N Fainting Y N Material allergies (latex, wool, metal, chemicals) Y N Asthma Y N Glaucoma Y N Mitral valve prolapse Y N Swelling of feet or ankles Y N Swelling or ankles Y N Swelling of feet or ankles Y N Swelling of fee					
Y N Anemia Y N Diabetes Malfunction Y N Skin rash Y N Epilepsy Y N Arthritis, Rheumatism Y N Fainting Y N Material allergies (latex, wool, metal, chemicals) Y N Artificial joints Y N God allergies Y N Material allergies (latex, wool, metal, chemicals) Y N Material allergies (latex, wool, metal, chemicals) Y N Mitral valve prolapse Y N Stroke Y N Stroke Y N Mitral valve prolapse Y N Mitral valve prolapse Y N Mitral valve prolapse Y N Swelling of feet or ankles Y N Mitral valve prolapse Y N Swelling of feet or ankles Y N Mitral valve prolapse Y N Swelling of feet or ankles Y N Mitral valve prolapse Y N Swelling of feet or ankles Y N Mitral valve prolapse Y N Swelling of feet or ankles Y N Mitral valve prolapse Y N Swelling of feet or ankles Y N Mitral valve prolapse Y N Swelling of feet or ankles Y N Mitral valve prolapse Y N Swelling of feet or ankles Y N Mitral valve prolapse Y N Swelling of feet or ankles Y N Mitral valve prolapse Y N Swelling of feet or ankles Y N Mitral valve prolapse Y N Swelling of feet or ankles Y N Mitral valve prolapse Y N Swelling of feet or ankles Y N Mitral valve prolapse Y N Swelling of feet or ankles Y N Swelling of feet or ankles Y N Mitral valve prolapse Y N Swelling of feet or ankles Y N Mitral valve prolapse Y N Swelling of feet or ankles Y N Thyroid disease Y	☐ Y ☐ N AIDS/HIV Positive	☐Y ☐N Cough, persistent	☐ Y ☐ N Jaw pain	□ Y □ N Shingles	
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Y N Artificial heart valves Y N Fainting Y N Artificial points Y N Food allergies (latex, wool, metal, chemicals) Y N Stroke (latex, wool, metal,					
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Y N Atopic (allergy prone) Y N Headaches Y N Nervous problems Y N Packemaker/ Heart surgery Y N Packemaker/ Y N Packemaker/ Y N Packemaker/ Y N Packemaker/ Y N Nervous problems Y N Packemaker/ Y N Pac					
Y N Nervous problems Y N Heart murmur Y N Pacemaker/ Heart surgery Y N Norvous problems Y N Pacemaker/ Heart surgery Y N Pacemaker/ Y N Tobacco habit Y N Pacemaker/ Y			□ Y □ N Mitral valve prolapse		
Y N Blood disease Y N Heart problems Heart surgery Heart surgery N N N N N N N N N			☐ Y ☐ N Nervous problems		
Heart problems Y N Blood disease Y N Tobacco habit Y N Cancer Y N Chemical dependency Y N Hemophilia/ Abnormal bleeding Y N Rapid weight gain or loss Y N Repsiratory disease Y N N Respiratory disease Y N N Respiratory disease Y N Venereal disease Y N Respiratory disease Y N Venereal disease Y N Respiratory disease Y N Venereal disease Y N Respiratory disease Y N Respiratory disease Y N Venereal disease Y N Venereal disease Y N Respiratory disease Y N Venereal disease Y N Respiratory disease Y N Venereal disease Y N Respiratory disease Y N Venereal disease Y N Venereal disease Y N Respiratory disease Y N Venereal dis			□Y □ N Pacemaker/		
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Is patient currently taking any medications? If yes, list all: Does patient have drug allergies? If yes, list all: AUTHORIZATION I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this informative dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will informative the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for service rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financial			□ Y □ N Respiratory disease		
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Signature Date				Date	