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	First Name	Initial		
CityCell Phone	Ctoto			
Cell Phone		7in	Hama Phana	
	State	ZIP	nome Phone	
			rried □ Widowed □ Separated	d D Divorced
Patient Employed by				
Business Address				
Business Email				
Whom may we thank for referring you?		Anna ang hija sa a		
Notify in case of emergency				
Cell Phone				
Email				
	Drima	ny Incuran	co	
ALCOHOLOGICA SIGNATURE SIG	Tillia	ry Insuran	CE	
Person Responsible for Account	Last Name		First Name	Initial
Relation to Patient	Birthdate		Soc. Sec. #	
Address (if different from patient)			Home Phone	
Dity		State		
Cell Phone			- "	
Person Responsible Employed by				
Business Address				
Business Email				
nsurance Company			Phone	
nsurance Email				
Contract #			Subscriber #	
Name of other dependents under this plar			Subscriber #	
tame of other dependence and of the plan		1.		
	Additio	nal Insura	nce	
s patient covered by additional insurance	? □Yes □No			
Subscriber Name	Relation to	Patient	Birthdate	
Address (if different from patient)			Soc. Sec. #	
Dity	State	Zip	Home Phone	
Cell Phone			Email	
Subscriber Employed by			Business Phone	
Business Email				
Insurance Company			Phone	
Insurance Email				
			Subscriber #	

Dental History

What would you like us to do to	oday?	Are you in dental dis	comfort today?
Former Dentist	Address	and the state of t	Last Basse of the last 1814
Dentist's Email	Phone _		
	ve had problems with any of the fol		
☐Y ☐ N Bad breath	☐ Y ☐ N Food collection between teeth	•	DV DN Consitivity to supply
☐ Y ☐ N Bleeding gums	☐ Y ☐ N Grinding or clenching teeth	☐ Y ☐ N Sensitivity to cold	☐ Y ☐ N Sensitivity to sweets
	☐ Y ☐ N Loose teeth or broken fillings		☐ Y ☐ N Sores or growths in mou
		,	
		Floss?	
How do you feel about the appe			700
	n adverse reaction during or in co		tal procedure? 🗆 Y 🗅 N
Other information about your de	ental health or previous treatment_		
	Medical	History	
Dhusisianis			
Physician's name		Phone	
	Have you had any	serious illnesses or operations?	OY ON
If yes, describe			
Are you currently under physicia	an care? DY DN If yes, des	cribe	
Have you ever had a blood trans	sfusion? DY DN If yes, give	approximate dates	
Have you ever taken Fen-Phen/	Redux? DY DN		
Women: Are you pregnant?	Y ON Nursing? OY ON	Taking birth control pills? □ Y	ΠN
	you have had any of the following:	Talling and contact place.	
☐ Y ☐ N AIDS/HIV Positive ☐ Y ☐ N Anaphylaxis	☐ Y ☐ N Cough, persistent ☐ Y ☐ N Cough up blood	□Y □N Jaw pain	□Y □N Shingles
□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 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,	☐ Y ☐ N Surgical implant
□Y □N Asthma	□Y □N Glaucoma	chemicals)	☐ Y ☐ N Swelling of feet
□ Y □ N Atopic (allergy prone)	☐ Y ☐ N Headaches	☐ Y ☐ N Mitral valve prolapse	or ankles
□ Y □ N Back problems	☐ Y ☐ N Heart murmur	☐ Y ☐ N Nervous problems ☐ Y ☐ N Pacemaker/	□ Y □ N Thyroid disease or
□Y □N Blood disease	□ Y □ N Heart problems	Heart surgery	malfunction
□Y □N Cancer	Describe	☐ Y ☐ N Psychiatric care	□ Y □ N Tobacco habit
□ Y □ N Chemical dependency	☐ Y ☐ N Hemophilia/	☐ Y ☐ N Rapid weight gain or loss	☐ Y ☐ N Tonsillitis
□ Y □ N Chemotherapy	Abnormal bleeding	□ Y □ N Radiation treatment	☐ Y ☐ IN Tuberculosis
□ Y □ N Circulatory problems	☐ Y ☐ N Hepatitis	□ Y □ N Respiratory disease	☐ Y ☐ N Ulcer/Colitis
□ Y □ N Cortisone treatments	☐ Y ☐ N High blood pressure	☐ Y ☐ N Rheumatic/Scarlet fever	☐ Y ☐ N Venereal disease
Is patient currently taking any m		Does patient have drug allergie	s? If ves. list all:
	Α (1		
	Author	rization	
I have reviewed the information of will be used by the dentist to he I will inform the dentist.	on this questionnaire, and it is accur elp determine appropriate and heal	rate to the best of my knowledge. thful dental treatment. If there is	I understand that this information any change in my medical status
	pany indicated on this form to pay	to the dentist all insurance bene	efits otherwise navable to me fo
services rendered. I authorize th	he use of this signature on all insur-	ance submissions.	onto otherwise payable to me ic
	se all information necessary to se		understand that I am financially
Signature			Date

Payment is due in full at time of treatment, unless prior arrangements have been approved.