Patient Informa	ation					Dat	te:/			
☐Mr. ☐Mrs. ☐	JMs. □Dr.	First Name:			M.I. L	ast:	10.155			
□Male □F				Age:_	Soc. S	Sec. #:				
Street:		City:		50259 13	State: Zip	: Em	ail:			
Home Tel. :		Cell:			Best Time To I	Be Reached				
Previous Dentist: Last Visit Date:										
		se Contact:								
Driver's License	Number:	CONTRACTOR OF DECISION	Employer:	:		_ Job Title:		71 300 3 7 1		
Family Members	Seen By Us	:				<u> </u>				
Who Will Be Re (If self, skip to ne	esponsible ext section)	For Your Accou	nt? □Self .	∐Spo	ouse □Father □	☑ Mother ☐	Other: _			
Name:		S.S	5.#		Birth Date:					
Street:		City:	St	ate: _	Zip:	Tel.:				
Employer:		Posi	tion:	_	Bı	ıs. Tel.:			_	
Spouse/Guarar	ntor Inform	ation(if different	from above)							
		Relation			S.S.#:		Birth D	ate:/	_/	
The state of the s		City:								
Employer:		Pos	sition:		E	Bus. Tel.:				
Insurance Infor										
☐ Student		e □ Part-Time	e □ Not		School Name:					
☐ Employed	☐ Full-Tim				☐ Unemployed	10				
	☐ Divorced		d □Singl		☐ Widow/er	☐ Other: _				
							-			
Primary Dental	Insurance	Company		5	econdary Der	itai insura	nce			
Employer:					Employer:					
Bus. Address: _					Bus. Address: _					
Bus. Tel.: Plan:					Bus. Tel.: Plan:					
Ins. Company Name:					Ins. Company Name:					
PROMOTE THE PROPERTY OF THE PR				11.5	Address:				- 3	
									- 12	
E	1	el.:					Tel.:			
Group #:		_ Group Name:			Group #:		Group N	ame:		
Insured Party: _					Insured Party: _					
Relation:		Male	Female		Relation:		_	Male	Female	
Birth Date: /	1	Tel.:			Birth Date:/_	1	Tel.:			
(Carried Constitution of the Constitution of t			- 22	11.0	Street:					
City:		State: Zip: _			City:					
Tel.:	5.7	_ S.S.#:			Tel.:		S.S.#: _	- 0.5 x x x x 2.5		
I.D. #:					I.D.#					
	97		- Indian		100					
Dental Informat		Reason For Toda	ay's Visit:			Dental Visit				
		No; If yes, for how				ty to: 🔲 Hot	☐ Cold	☐ Sweets	∃ Biting	
Jaw clicking/poppi		lowing problems by Lost/broken fillings		or greeting to	onding box:	Difficulty op	oning isw	Prolor	nged bleeding	
Red/swollen/bleed	ding gums	Clenching/grinding	Stained teeth	☐ Re	movable appliance	_ Difficulty clo	sing jaw	Other	iged bleeding	
Oral blisters/sores Recent infection/s		Ringing in ears	Locking jaw Bad breath	Bu	rning tongue/lips ose/shifting teeth	Food catche Swelling/lur	es in teeth	th —		
	ore unoat	broken/chipped tooth	bad breath		bersmang teetn	Swelling/lur	npa in mou	MI ==		
Times a day you	brush:	Times a	week you floss	s:		How wo	ould you	ate your	smile?	

(worst) 1 2 3 4 5 6 7 8 9 10 (best)

Would you like whiter teeth? ☐ Yes ☐ No

Medical History			
Are you in good health? L Have you had any illness,o	Yes No Are you under peration, or been hospitalized i	r a physician's care?  Yes No n the past five years?  Yes	Date of last visit:
If so, please explain:			
[ [ B C. 10 M C	이 하나 많은 아이 아이에 가게 되어 보니? 나를 보는 내가 되었다면 살아 되었다.	ing diseases, medical condition	등대 중심하장이 하다 하고 하다 하는 가지 아니는 아이를 하고 있다면 하는데
Y N  Rheumatic fever Heart murmur Mitral valve prolapse High blood pressure Chest pain/ Angina Heart attack(s) Cardiac pacemaker	Y N  Asthma  Hay fever/ Sinus problems  Snoring/ Sleep Apnea  Problems w/immune system  Bleeding tendency  Jaundice/ Liver disease  Hepatitis  Infectious mononucleosis  Gallbladder trouble	Y N  Swollen ankles  Malignant hyperthermia  Low blood sugar  Kidney trouble  Are you on dialysis?  Arthritis/ Joint disease  Osteoporosis/ Osteopenia  Costeonecrosis  Respiratory problems	Y N      History of drug abuse     Eye disease/ Glaucoma     Abnormal bleeding     Herpes/ Fever blisters     Stomach ulcers     Contagious diseases     Delay in healing     Anemia     Tumor or growth
Heart surgery Bronchitis/ Chronic cough Chronic fatigue/ Night sweats Difficulty climbing stairs Mental health problems Damaged heart valves Are you immunosupressed?	Fainting/ Dizzy spells Convulsions/ Epilepsy Stroke Thyroid trouble Diabetes History of alcohol abuse Sexually transmitted diseas	Tuberculosis Emphysema Do you smoke? Do you use chewing tobacco? Blood transfusion Blood disorder	Radiation/ Chemotherapy   Are you on a diet?   Contact lenses   HIV/ AIDS   Other:
Medication and Allergies	1		
Are you taking now, or have you you will be a special be	oirin, Advil) Aredia, Zometa, n(s) you are taking	Are you allergic to, or had a reaction of the control of the contr	
your physician/ gynecologi Y N	such as Penicillin) may alter the st for assistance regarding add there a possibility of pregnance ate:	e effectiveness of birth control pills. Co litional methods of birth control.) by?	nsult
answered to my satisfaction. I will	rstand the questions above. I ackn not hold my doctor, or any other m	owledge that my questions, if any, about the	e inquiries set forth above have beer errors or omissions that I have made
in the completion of this form. Signature of patient: (Parent/Guardian if minor)	Date:	Reviewed by:	Date:
Fees and Payments  We make every effort to keep down with our office manager depending to you upon request. If you have an information on this form. Please resubstitute for payment. Some companyment.	ny dental and/ or medical insuranc member that insurance is consider panies pay fixed allowances for ce ible amount, co-insurance or an	elp by paying upon completion of each visit stimate of the charge for any procedure/ sit we will be glad to fill out the proper forms red a method of reimbursing the patient for rtain procedures and others pay a percentary other balance not paid by your insural	fees paid to the doctor and is not a age of the charge. It is your
Signature of patient: (parent or guardian if mi	inor)	Date:	
otherwise payable to me.  Signature of patient: (parent or guardian if m  I hereby acknowledge that a cop	nor) by of this office's Notice of Priva	Date:  Cy Practices has been made available to	
opportunity to ask any questions I Signature of patient: (parent or guardian if mi	may have regarding this Notice.	Date:	