Welcome

Patient Information

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.

Name			Soc. Sec. #	
Last Name	First Name	Initial	Soc. sec. #	
Address	TAILWINE TO CO.	(F. Carrier)		
City		Zip	Home Phone	
Cell Phone				
Sex DM DF Age Birthd			arried Widowed Separate	ed Divorced
Patient Employed by			Occupation	
Business Address			Business Phone	
Business Email			The second secon	
Whom may we thank for referring you?				
Notify in case of emergency				
Cell Phone				
Email			No.	
Primary Insurance				
Person Responsible for Account	Last Name		First Name	Initial
Relation to Patient				10000000
Address (if different from patient)			Home Phone	
Cell Phone			Email	
		State		
Person Responsible Employed by			Occupation	
Business Address			Business Phone	
Business Email			Dusiness Filone	
nsurance Company			Phone	
Insurance Email				
	Group #_		Subscriber #	
Name of other dependents under this plan			Substitute #	
Name of other dependents dition this plan				
Additional Insurance				
	1236			
s patient covered by additional insurance				
Subscriber Name	Relation t	o Patient	Birthdate	
Address (if different from patient)			Soc. Sec. #	
City	State	Zip	Home Phone	and the second
Cell Phone			Email	1(8,80-
Subscriber Employed by			Business Phone	
Business Email				
insurance Company			Phone	
Insurance Email			the state of	April 1
			Subscriber #	

Dental History						
What would you like us to do to	day?		_ Are you in dental dis-	comfort tod	ay?	
Former Dentist	Address		Carried and the second	12-10-11	W. C.	
Dentist's Email	Phone _					
	ve had problems with any of the fo					
Y □ N Bad breath □ Y □ N Food collection between teeth □ Y □ N Grinding or clenching teeth □ Y □ N Clicking or popping jaw □ Y □ N Loose teeth or broken fillings		יביים מביים	☐ Y ☐ N Periodontal treatment ☐ Y ☐ N Sensitivity to cold		☐ Y ☐ N Sensitivity to sweets ☐ Y ☐ N Sensitivity when biting ☐ Y ☐ N Sores or growths in mout	
How often do you brush?			Floss?		. E. C.	
	earance of your teeth?					
	adverse reaction during or in co		with a medical or deni	tal procedu	re? DY DN	
	ental health or previous treatment_					
Other internation acoust four de	and round or provided it consists.					
Medical History						
			Phone			
The same of the sa	Have you had any					
If yes, describe		Serious IIII	lesses or operations?	31 314		
Are you currently under physicia		ecriba				
Have you ever had a blood tran						
Have you ever taken Fen-Phen		e approxim	nate dates			
The state of the s		Table - h				
	Y IN Nursing? IY IN		pirth control pills?	JN		
Check (/) yes or no whether y	you have had any of the following:					
DY DN AIDS/HIV Positive	☐ Y ☐ N Cough, persistent	SYDN	Jaw pain	DYDN	Shingles	
☐ Y ☐ N Anaphylaxis	☐ Y ☐ N Cough up blood	SALA	Kidney disease or malfunction		Shortness of breath	
☐ Y ☐ N Anemia ☐ Y ☐ N Arthritis, Rheumatism	☐ Y ☐ N Diabetes ☐ Y ☐ N Epilepsy	DYDN	Liver disease		Skin rash	
☐ Y ☐ N Artificial heart valves	OYON Fainting		Material allergies	DYDN	Spina Bifida Stroka	
DY DN Artificial joints	DY DN Food allergies		(latex, wool, metal, chemicals)		Surgical implant	
☐ Y ☐ N Asthma	☐ Y ☐ N Glaucoma	OVON	Mitral valve prolapse		Swelling of feet	
☐ Y ☐ N Atopic (allergy prone)			Nervous problems	DVDN	or ankles	
☐ Y ☐ N Back problems	☐ Y ☐ N Heart murmur	T	Pacemaker/	אניינ	Thyroid disease or malfunction	
☐ Y ☐ N Blood disease ☐ Y ☐ N Cancer	☐ Y ☐ N Heart problems Describe		Heart surgery	DYDN	Tobacco habit	
☐ Y ☐ N Chemical dependency	☐ Y ☐ N Hemophilia/		Psychiatric care Rapid weight gain or loss	SASM	Tonsillitis	
☐ Y ☐ N Chemotherapy	Abnormal bleeding ☐ Y ☐ N Herpes		Radiation treatment		Tuberculosis	
☐ Y ☐ N Circulatory problems	☐ Y ☐ N Hepatitis	DYDN	Respiratory disease		Ulcer/Colitis Venereal disease	
☐ Y ☐ N Cortisone treatments	☐ Y ☐ N High blood pressure	DADM	Rheumatic/Scarlet fever	3131	venereal disease	
Is patient currently taking any m	edications? If yes, list all:	Does par	tient have drug allergie	s? If ves. lis	st all:	
11/2			11111			
2 02 2						
Authorization						
I have reviewed the information will be used by the dentist to he I will inform the dentist.	on this questionnaire, and it is according to the determine appropriate and heat	urate to the ithful denta	best of my knowledge. I treatment. If there is	I understar any change	nd that this information in my medical status	
I authorize the insurance comp services rendered. I authorize to	pany indicated on this form to pay he use of this signature on all insu	to the der	ntist all insurance bene nissions.	ofits otherw	ise payable to me fo	
	se all information necessary to s			understand	d that I am financially	
Signature				Det		
Signature	196		988	Date		