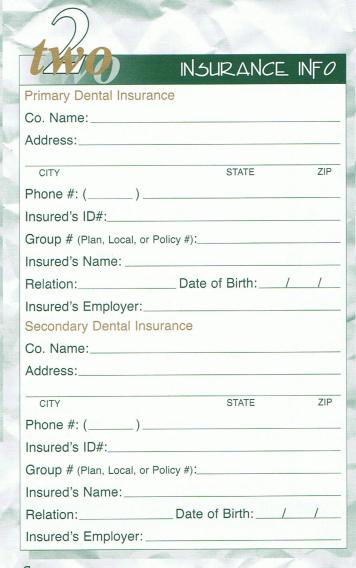
WELLCOME



ABOUT YOU

Today's Date:/ Patient Name:	1		
LAST		FIRST	MI
What You Prefer To Be Called:			☐ Male ☐ Female
Birthdate:/Age:_	Loss	SS#:	
Mailing Address:			
CITY	STA	_	ZIP
Home Phone #: ()			
Work Phone #: ()			Ext:
Cell Phone #: ()	<u> </u>		
E-mail Address:			
Referred By:			
Employer:		How l	Long?
Employer's Address:		<u> </u>	
CITY	STA	TE	ZIP
Occupation:			
Status: ☐ Minor ☐ Single ☐ Married ☐	Divor	ced 🗆 Sepa	arated Widowed
Spouse's Name:	1111		<u> </u>
Do you have children? ☐ Yes ☐ N	No	How mar	ny?





(if offered at this office).

	IN EVENT OF EMERGENCY
Whom s	hould we contact?
Relation	
Home P	none #: ()
Work Ph	one #: ()
Cell Pho	ne #: ()
Who is y	rour Medical Doctor?
Medical	Doctor's Phone #: ()

PLEASE CONTINUE ON BACK

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DENTAL INFORMATION
Reason for today's visit: Exam Emergency Consultation Are you in pain? No Yes How Long? Please indicate any of the following problems: Discomfort, clicking or popping in jaw. Lost/Broken Filling(s) Stained teetl Red, swollen or bleeding gums. Teeth grinding Locking Jaw Sensitive tooth, teeth or gums. Ringing in Ears Bad breath Blisters/Sores in or around the mouth. Broken/Chipped tooth
Other: Do you require pre-medication? ☐ Yes ☐ No ☐ Don't know Previous Dentist: ()

Last Dental exam:

Times a day you brush?_



Initials

Signature

☐ Adult Patient

direction of the second		ush bristles do you use? your smile? (Worst) 1 2 3			☐ Hard 1 0 (E
	Tible Wedie you take y			115T0R	ZY
☐ Other(s), please list:	d Thinners Tranquiliz	zers 🗆 Insulin 🚨 Med	ds for Osteo	oporosis	
Have you ever taken: E Do you have or have you	Bisphosphonates (ex. Aredia u had any of the following o	diseases, medical conditio	ns or proce	Redux Yes dures?	□ INO
Y N Heart Attack / Stroke Y N Heart Surg./Pacemaker Y N Heart Murmur Y N Rheumatic Fever Y N Mitral Valve Prolapse	Y N Thyroid Problems	Y N Cancer/Tumors Y N Shingles Y N Hepatitis Y N HIV+/AIDS/ARC Y N Arthritis/ Rheumatism	YN Cos YN Xray YN Che YN Asth	metic Surgery y or Cobalt Treat emotherapy	ment

Last Dental X-rays:_

Times a week you floss?_

Other(s), please list:		3.991 +- 5.101 181	
Have you ever taken: E	Bisphosphonates (ex. Aredia/		en-fen/Redux 🗆 Yes 🗅 No
Do you have or have you	ı had any of the following di	seases, medical conditions of	or procedures?
Y N Heart Attack / Stroke	Y N Thyroid Problems	I II Odinoon ranner	Y N Cosmetic Surgery
	Y N Kidney Problems		Y N Xray or Cobalt Treatment
Y N Heart Murmur	Y N Liver Problems	1 14 Hopathio	Y N Chemotherapy Y N Asthma
Y N Rheumatic Fever	Y N Respiratory Problems	Y N HIV+/AIDS/ARC	Y N Difficulty Breathing
Y N Mitral Valve Prolapse	Y N Sinus Problems	Y N Arthritis/ Rheumatism	Y N Diabetes/Hypoglycemia
Y N Artificial Valves	I II Otomicom i robiomo dice.	Y N Artificial Bones/Joints	Y N Leukemia
Y N Heart Disease	Y N Psychiatric Problems	Y N Emphysema	
Y N Congenital Heart Defect		Y N Fainting/Seizures/Epilepsy Y N Severe/Frequent Headaches	V N High/I ow Blood Pressure
Y N Chest Pains	Y N Alcohol/Drug Abuse		Y N Bleeding Problems
Y N Scarlet Fever	Y N Tuberculosis TB	Y N Frequent Neck Pain Y N Back Problems	Y N Glaucoma
Y N Nervousness	Y N Jaw Problems TMJ/TMD	Y N Back Problems	N Gladcoma
Please list any other su	urgeries or medical condition	ons you have or ever had: _	
Are you allergic to any	of the following? Latex	☐ Penicillin / Amoxicillin ☐	Tetracycline Aspirin
Doutel Ameethotics	⊒ Foods:	• Others:	
		How much?	
Please rate your gener For women: Are you to	al health from 1-10: aking Birth Control pills? □	Do you wear cont I Yes □ No How many child	act lenses? ☐ Yes ☐ No dren have you had?
Are you Pregnant?		Are you nursing? Ye	

♦ We invite you to discuss with us any questions regarding our services	. The	best	Denta	l health	services	are	based
on a friendly, mutual understanding between provider and patient.							

- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- ◆ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- ◆ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of

I acknowledge that I have received a copy of the Summary of Privacy Notic	e.
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m this office of any eceived a copy o	y changes to	the informa	tion I h	ave prov	ided.	J
		Date_	/	/		
☐ Parent or Guardian	☐ Spouse					

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