Patient Information	C) Dental I	Insurance	
Date	Wh		r this account?	
			it	
SS/HIC/Patient ID #				
Patient Name Last Name				
First Name	ACT III TO I		additional insurance? Yes	
Address			additional insurance: res	
E-mail	00.		SS#	
City			it	
State Zip			7.	
Sex				
Birthdate		SIGNMENT AND RE		
☐ Married ☐ Widowed ☐ Single	☐ Minor	certify that I, and/o	or my dependent(s), have insurance	ce coverage with
☐ Separated ☐ Divorced ☐ Partnered f	or years	Name of Inst	urance Company(les)	assign directly to
Patient Employer/School	Dr		all in:	surance benefits, if
Occupation			to me for services rendered. I und r all charges whether or not paid by ins	
Employer/School Address		, ,	on all insurance submissions.	
	suc	ch information to the a	st may use my health care information bove-named Insurance Company(ies)	and their agents for
Employer/School Phone ()	or ti	he benefits payable for	payment for services and determining or related services. This consent will er	nd when my current
Spouse's Name		atment plan is comple	ted or one year from the date signed b	elow.
Birthdate		Signature of Patie	ent, Parent, Guardian or Personal Repr	resentative
SS#		Please print name of	Patient, Parent, Guardian or Personal	Representative
Spouse's Employer		F		
Whom may we thank for referring you?		Date	Relationship to	Patient
Phone Numbers		10 68 68 58	The State of the S	DATE OF THE PARTY.
Home ()	Work ()	Ext	Alt. Phone ()	
Spouse's Work ()				
IN CASE OF EMERGENCY, CONTACT (Specify s				
Name	Relati	ionship		
Phone ()	Alt. Pr	hone ()		
Dental History	A STATE OF THE PARTY OF THE PAR	7 - 17 - 17 - 17 - 17 - 17 - 17 - 17 -	SHIP CHEET AND	
	Duming concetion on tongue	□Vaa □Na	Mouth broathing	□Vos □No
Reason for today's visit	Burning sensation on tongue Chew on one side of mouth	☐ Yes ☐ No	Mouth breathing Mouth pain, brushing	☐ Yes ☐ No
Former Doubles	Cigarette, pipe, or cigar smoking	g 🗌 Yes 🗌 No	Orthodontic treatment	☐ Yes ☐ No
Former Dentist	Clicking or popping jaw Dry mouth	☐ Yes ☐ No	Pain around ear Periodontal treatment	☐ Yes ☐ No ☐ Yes ☐ No
City/State	Fingernail biting	Yes No	Sensitivity to cold	Yes No
Date of last dental V-rays	Food collection between the teeth		Sensitivity to heat	Yes No
Date of last dental X-rays	Foreign objects Grinding teeth	☐ Yes ☐ No	Sensitivity to sweets Sensitivity when biting	☐ Yes ☐ No ☐ Yes ☐ No
have had any of the following:	Gums swollen or tender	☐ Yes ☐ No	Sores or growths in your mouth	☐ Yes ☐ No
Bad breath Yes No Bleeding gums Yes No	Jaw pain or tiredness Lip or cheek biting	☐ Yes ☐ No	How often do you floss?	
Blisters on lips or mouth Yes No		Yes No	How often do you brush?	

Dental Registration and History

Physician's Name Name	Health Histor	ry				
Have you ever used a bepfosphoraben medication? Common brand names are Fosamax, Actorel, Alekina, Didronel, Boniva, — [ves New you ever tester any of the group of drugs collectivity referred to as "gre-phepe"? These indust constitutions of Ioninin, Adgiers, Fastin (brand names of phenfermine), Poderim (fernfuramine) and Rodux (discelluramine), — [ves No No No No No No No N	Di all'in la Ma				6.4.4	
New you seet later any of the group of drugs collectively referred to as "fen-plan?" These include combinations of loninin, Adipex, Pastin (brand names of phetrerinal). Powdering (infurramen) and Roux (dox/dontumations). New No Respiratory Disease No No	,	phonete modication	2 Common brand names	ara Facemov Actorial At		
Page a mark or phentermine), Pondimin (fenturamine) and Redux (destenturamine), Ves No No Page Page Page No Page Page Page No Page						
AlDSARIV	names of phentermine), Pondir	min (fenfluramine) a	and Redux (dexfenflurami	ne). 🗌 Yes 🗌 No	ombinations of Ionimin, Adipex,	, Fastin (brand
Anemia					Dansinstan Diana	
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Artificial Heart Valves			_			
Astimate						
Asthma						
Back Problems						
Bleeding abnormally, with extractions or surgery Yes No Herpes No Herpes No High Blood Pressure Yes No Swolien Feet or Ankles Yes No Swolien Feet or Ankles Yes No Swolien Feet or Ankles Yes No Yes No Swolien Feet or Ankles Yes No Yes Yes Yes No Yes Yes Yes No Yes Yes Yes Yes No Yes Ye						
Sevaluar Feet or Ankles		☐ Yes ☐ No				
Second S		□Vaa □Na				
Cancer						
Chemotherapy						
Chemotherapy						
Crouditory Problems						
Congenital Heart Lesions						☐ 162 ☐ 140
Cordisone Treatments Yes No Nervous Problems Yes No Cough, persistent or bloody Yes No Pacemaker Yes No Venereal Disease Yes No Pacemaker Yes No Weight Loss, unexplained Yes No Pacemaker Pacemaker Yes No Pacemaker Pacemaker Yes No Pacemaker Pacemaker Pacemaker Pacemaker Yes No Pacemaker Pacema					9	□ Yes □ No
Cough, president or bloody Yes No Pacemaker Yes No Venereal Disease Yes No No Diabetes Yes No Psychiatric Care Yes No Weight Loss, unexplained Yes No No Diabetes Yes No No Yes No No No Yes No No No No No No No N					Ulcer	
Diabetes Yes No Psychiatric Care Yes No Weight Loss, unexplained Yes No Emphysema Yes No Padiation Treatment Yes No Padiation Treatment Yes No Yes No Women: Are you pregnant? Yes No Due date Are you nursing? Yes No Taking birth control pills? Yes No Allergies List any medications you are currently taking and the correlating Aspirin Local Anesthetic Barbiturates (Sleeping pills) Penicillin Codeine Sulfa Iodine Other Latex Updates To be filled in at future appointments Has there been any change in your health since your last dental appointment? Yes No For what conditions? Date Date					Venereal Disease	
Emphysema Yes No Radiation Treatment Yes No No No No No No No N					Weight Loss, unexplained	☐ Yes ☐ No
Do you wear contact lenses? Yes No Women: Are you pregnant? Yes No Due date Are you nursing? Yes No Taking birth control pills? Yes No Allergies List any medications you are currently taking and the correlating diagnosis: Barbiturates (Sleeping pills) Penicillin						
Women: Are you pregnant? yes No			Hadiation heatment	☐ les ☐ No		
Are you pregnant? Ves		☐ fes ☐ No				
Taking birth control pills? Yes No Medications			Due date	Aro you n	uraina? 🗆 Vaa . 🗔 Na	
Medications	, , , , , , ,	_	Due date	Are you in	ursing! res No	
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Barbiturates (Sleeping pills) Penicitlin Codeine Sulfa Dotter Date	Me	dications	E COLE	0	Allergies	
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Updates (To be filled in at future appointments) Has there been any change in your health since your last dental appointment? \ Yes \ No For what conditions? \ If so, what? \ Date \ Doctor's Signature \ Date \ Date \ Date \ Are you taking any change in your health since your last dental appointment? \ Yes \ No For what conditions? \ Are you taking any new medications? \ If so, what? \ Patient's Signature \ Date \ Da	List any medications you are cudiagnosis:	urrently taking and		☐ Barbiturates (Sleepin☐ Codeine	☐ Local Anestling pills) ☐ Penicillin☐ Sulfa	
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