## 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**

Name	First Name	Initial	_ Soc. Sec. #			
Address		7in	Home Phone			
Cell PhoneSex						
Patient Employed by						
Business Address						
Business Email						
Whom may we thank for referring you?						
Notify in case of emergency						
Cell Phone						
Email						
		rimary Insurance				
D D						
Person Responsible for Account	Last Name		First Name	Initial		
Relation to Patient	Rirthdata		Soc Sec #			
Address (if different from patient)			. AV 855			
CityCell Phone			ZipEmail			
Person Responsible Employed by						
Business Address						
Business Email						
Insurance Company			_ rnone			
Insurance Email			0.1			
	cct # Group #					
Name of other dependents under this plan						
	Ad	ditional Insurance	e			
Is patient covered by additional insurance?	□ Yes □ No					
Subscriber Name	Relation to Patier	ıt	Birthdate			
Address (if different from patient)		Soc. Se	c. #			
City	State	Zip	Home Phone			
Cell Phone						
Subscriber Employed by						
Business Email						
Insurance Company						
Insurance Email						
Contract #						
2900 Anna Anna Call (1) (1) (2)			- AMMENYARITATI CLA			

Please complete both sides.

## **Dental History**

ormer Dentist		ne jou	in dental discomfort today	·	
	Address_				
entist's Email	Phone				
ate of last dental care		Date of last x-rays _			
eck ( 🗸 ) yes or no if you have had problems with any of the following: Y $\ $ N Bad breath Y $\ $ N Bleeding gums Y $\ $ N Grinding or clenching teeth Y $\ $ N Clicking or popping jaw W often do you brush? W do you feel about the appearance of your teeth?		rg: teeth	☐ Y ☐ N Periodontal treatment ☐ Y ☐ N Sensitivity to cold ☐ Y ☐ N Sensitivity to hot ☐ Y ☐ N Sores  Floss?		ensitivity to sweets ensitivity when biting ores or growths in mout
	rse reaction during or in conjuncti		1.7		
ther information about your dental	health or previous treatment				
		Medical Histo	ory		
hysician's name			Phone		
ate of last visit	Have you had any ser	rious illnesses or ope	erations?		
yes, describe		seessestatus eraseltetti attiisitti kii	000000000000 00000 0000000000000000000		
	re?  Y N If yes, describe_				
ave vou ever had a blood transfusio					
		oximate dates			
ave you ever taken Fen-Phen/Redux					
ave you ever used a bisphosphonate	e medication? Brand names include			a. 🗆 Y 🗀 N	
/omen: Are you pregnant? 🏻 Y 🔻	N Nursing? □ Y □ N Taki	ng birth control pill:	s? 🗆 Y 🗆 N		
heck ( 🗸 ) yes or no whether you l	have had any of the following:				
Y □ N AIDS/HIV Positive	☐ Y ☐ N Cough, persistent		Iaw pain	$\Box$ Y $\Box$ N	Shingles
IY □ N Anaphylaxis	☐ Y ☐ N Cough up blood		Kidney disease or		Shortness of breath
IY □ N Anemia	☐ Y ☐ N Diabetes		malfunction		Skin rash
Y 🗆 N Arthritis, Rheumatism	☐ Y ☐ N Epilepsy		Liver disease	$\Box$ Y $\Box$ N	Spina Bifida
Y N Artificial heart valves	☐ Y ☐ N Fainting		Material allergies	$\square$ Y $\square$ N	Stroke
Y N Artificial joints	□ Y □ N Food allergies		(latex, wool, metal, chemicals)	$\square$ Y $\square$ N	Surgical implant
IY 🗆 N Asthma	☐ Y ☐ N Glaucoma		Mitral valve prolapse	$\square$ Y $\square$ N	Swelling of feet
Y N Atopic (allergy prone)	□ Y □ N Headaches		Nervous problems		or ankles
Y 🗆 N Back problems	☐ Y ☐ N Heart murmur		Pacemaker/		Thyroid disease or malfunction
IY □ N Blood disease	☐ Y ☐ N Heart problems		Heart surgery		Tobacco habit
IY □ N Cancer	Describe	— ¬ ¬ ¬ ¬ ¬ ¬ ¬ ¬ ¬ ¬ ¬ ¬ ¬ ¬ ¬ ¬ ¬ ¬ ¬	Psychiatric care		Tonsillitis
Y □ N Chemical dependency	☐ Y ☐ N Hemophilia/ Abnormal bleeding	$\Box$ Y $\Box$ N			Tuberculosis
IY □ N Chemotherapy	□ Y □ N Herpes		Radiation treatment		Ulcer/Colitis
IY □ N Circulatory problems	□ Y □ N Hepatitis		Respiratory disease		Venereal disease
Y N Cortisone treatments	☐ Y ☐ N High blood pressure		Rheumatic/Scarlet fever		
patient currently taking any medica	tions? If yes, list all:	Does patier	nt have drug allergies? If y	es, list all:	

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