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			Soc. Sec. #	
	First Name	Initial		
Address	Ctoto	Zin	Homo Dhono	
Cell Phone			nome Phone	
Sex DM DF AgeBirthdat			Married D Widowed D Separated	I □ Divorced
Patient Employed by			Business Phone	
Business Email				
Whom may we thank for referring you?				
Notify in case of emergency				
	Business Phone			
Email				
	PRIMA	RY INSURA	ANCE	
Person Responsible for Account	Last Name		First Name	Initial
Relation to Patient				
Address (if different from patient)				
City				
			Email	
Person Responsible Employed by				
Business Address			Business Phone	
Business Email				
Insurance Company			Phone	
Insurance Email				
Contract #	Group #	THE CONTRACT OF THE PARTY OF TH	Subscriber #	
Name of other dependents under this plan				
	ADDITIO	NAL INSUE	IANCE	
Is patient covered by additional insurance?	☐ Yes ☐ No			
Subscriber Name		o Patient	Birthdate	
Address (if different from patient)			Soc. Sec. #	
City				
Cell Phone				
Subscriber Employed by				
Business Email				
			Phone	
Insurance CompanyInsurance Email			Thone	

Please complete both sides.

DENTAL HISTORY

What would you like us to do to	Address					
	Phone _					
Data of last dontal care	1 Hone _	Data of las	t v.rove			
			i X-rays			
	re had problems with any of the fo					
☐ Y ☐ N Blackling average	Y N Food collection between teeth			☐ Y ☐ N Sensitivity to sweets		
	□ Y□ N Grinding or clenching teeth□ Y□ N Loose teeth or broken fillings		□ Y □ N Sensitivity to cold □ Y □ N Sensitivity when biting □ Y □ N Sensitivity to hot □ Y □ N Sores or growths in mou			
	arance of your teeth?					
	adverse reaction during or in co					
Other information about your de	ntal health or previous treatment_					
	MEDICAL	HISTO	RY			
Physician's name			Phone			
	Have you had any					
If yes, describe		serious IIIn	esses or operations?			
		.1				
	an care? DY DN If yes, des					
Have you ever had a blood trans		e approxima	ate dates			
Have you ever taken Fen-Phen/						
Have you ever used a bisphosp	honate medication? Brand names i	nclude Fosa	ımax, Actonel, Atelvia, D	idronel and Boniva. □Y □N		
Women: Are you pregnant?	Y □ N Nursing? □ Y □ N	Taking b	irth control pills? □ Y	□N		
Check (✓) yes or no whether y	ou have had any of the following:					
☐Y☐N AIDS/HIV Positive	□ Y □ N Cough, persistent	OYON	Jaw pain	□Y □ N Shingles		
□Y □ N Anaphylaxis	□ Y □ N Cough up blood		Kidney disease or	☐ Y ☐ N Shortness of breath		
□Y□N Anemia	□Y □ N Diabetes		malfunction	□ Y □ N Skin rash		
□ Y □ N Arthritis, Rheumatism	□ Y □ N Epilepsy		Liver disease	□ Y □ N Spina Bifida		
□ Y □ N Artificial heart valves	□ Y □ N Fainting	UYUN	Material allergies (latex, wool, metal,	□ Y □ N Stroke		
□ Y □ N Artificial joints	□ Y □ N Food allergies		chemicals)	☐ Y ☐ N Surgical implant		
□ Y □ N Asthma	□ Y □ N Glaucoma		Mitral valve prolapse	☐ Y ☐ N Swelling of feet or ankles		
□ Y □ N Atopic (allergy prone)□ Y □ N Back problems	☐ Y ☐ N Headaches		Nervous problems	☐ Y ☐ N Thyroid disease or		
☐Y☐N Blood disease	☐ Y ☐ N Heart problems	DYDN	Pacemaker/ Heart surgery	malfunction		
□Y □N Cancer	Describe	DYDN	Psychiatric care	☐ Y ☐ N Tobacco habit		
□ Y □ N Chemical dependency	□Y□N Hemophilia/		Rapid weight gain or loss	□ Y □ N Tonsillitis		
□ Y □ N Chemotherapy	Abnormal bleeding		Radiation treatment	□ Y □ N Tuberculosis		
□ Y □ N Circulatory problems	☐ Y ☐ N Herpes ☐ Y ☐ N Hepatitis		Respiratory disease	☐ Y ☐ N Ulcer/Colitis ☐ Y ☐ N Venereal disease		
☐ Y ☐ N Cortisone treatments	☐ Y ☐ N High blood pressure	OYON	Rheumatic/Scarlet fever	TI TIN Venereal disease		
s patient currently taking any m						
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	AUTHOR	TZATIC	V			
	No I HOL	LIEUTAL IV	The second secon			
	on this questionnaire, and it is acc					
will be used by the dentist to help the dentist.	determine appropriate and healthful	dental treat	ment. It there is any chan	ige in my medical status,I will infori		
	ny indicated on this form to pay to t	he dentiet o	all insurance henefite of	perwise navable to me for service		
	is signature on all insurance submis		m mourance benefits Off	Torwise payable to file for Service		
I authorize the dentist to relea	se all information necessary to s		payment of benefits. I	understand that I am financial		
responsible for all charges whether	ы он посраки ву изчиталсе.					