



Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

PATIENT INFORM	MATION	i sans i a					
Date	Soc. Sec. #	Birthdate					
Name	Pinet Name	Home Phone					
			Cell Phone				
City		State	Zip	E-mail			
Sex: M F	☐ Minor ☐ Single	Married	☐ Long Term Partner	Divorced	Widowed	☐ Separated	
Employer		Business Phone					
Business Address	Occupation						
Who should we thank for re	eferring you?		70,				
In case of emergency, who	should we contact?			Phone			
PRIMARY DENTA	AL INSURANCE						
Person Responsible for Acc	ountLast Name		First Name			Initial	
Relationship to Patient		Birthdate	S				
Address				Home Phone			
City		<u>}</u>	State		Zip		
Responsible Party Employe	d By			Business Pl	none		
Business Address	- 'b'.		Оссі	ıpation			
Insurance Company					· · · · · · · · · · · · · · · · · · ·		
Insurance Company Addres	\$					· · · · · · · · · · · · · · · · · · ·	
Subscriber I.D. #		-	Group #				
ADDITIONAL INS	SURANCE						
Insured Name	Last Name		First Name			Initial	
Relationship to Patient		Birthdate		Soc. Sec. #			
Address			Home Phone				
City			State		Zip		
Insured Employed By			Bu	siness Phone			
Insurance Company							
Insurance Company Addres	s						
Subscriber I.D. #			Group #	*****			
	,	Please compl	ete reverse side				

DENTAL HISTORY				
Former Dentist	_			
City, State	_	How Often Do You Flo	ss?	
Date of Last Dental Visit	H	How Often Do You Bru	ısh?	
Please check all that apply:			·	
Bad Breath	Loose Teeth or Broken	Fillings	Sensitivity to Sweets	
Bleeding Gums	Orthodontic Treatment		Sensitivity When Biting	
Blisters on Lips or Mouth	Pain Around Ear		Frequent Headaches	
Finger Nail Biting	Periodontal Treatment.		Jaw, Head or Neck Injuries	
Grinding Teeth	Sensitivity to Cold		Jaw Difficulty: Clicking and/or Pain[
Lip or Cheek Biting	Sensitivity to Heat		Tooth Pain	
MEDICAL HISTORY				
Physician's Name			Date of Last Visit	
Are you currently under medical treatment	Yes No 7	7. Have you had any a	llergic reactions to the following:	
			Yes	
2. Have you ever had any serious illnesses		the state of the s	hetics (eg. novocaine)	
or operations?			r other Antibiotics	
3. Are you currently taking any medication?		_	3 [] [
Please describe:		Barbiturates (sleeping pills)		
r rease describe.				
·				
. Do you smoke?				
Do you use alcohol, cocaine or other drugs		Other 3. (Women Only) Are		
5. Do you wear contact lenses?				
	.,,'0		h control pills?	
Please check all that apply:		runing birt	ii control pino.	
AIDS	Emphysema		Pacemaker	
Anemia	Epilepsy		Psychiatric Care	
Arthritis, Rheumatism	Fainting or Dizziness		Radiation Treatment	
Artificial Heart Valves	Glaucoma		Respiratory Disease	
Artificial Joints	Headaches		Rheumatic Fever	
Asthma	Heart Murmur		Scarlet Fever	
Back Problems	Heart Problems		Shortness of Breath	
Bleeding abnormally,	Hepatitis-Type		-	
vith extractions or surgery	Herpes	***************************************	Sinus Trouble	
Blood Disease	High Blood Pressure	-	Skin Rash	
Cancer	HIV Positive		Stroke	
			Swelling of Feet/Ankles	
Chemical Dependency	Jaundice	LI	Swollen Neck Glands	
Chemotherapy	Jaw Pain	L	Thyroid Problems	
Chronic Fatigue Syndrome	Latex Sensitivity		Tonsillitis	
Circulatory Problems	Kidney Disease		Tuberculosis	
Congenital Heart Lesions	Liver Disease		Tumor or growth on head/neck	
Cortisone Treatments	Low Blood Pressure		Ulcer	
Cough - persistent or bloody	Mitral Valve Prolapse Nervous Problems		Venereal Disease	
ASSIGNMENT AND RELEA				
	OL	c		
hereby authorize payment directly to services rendered. I understand that I am fir rendered on my behalf or my dependents.	ancially responsible for all	for all insurate charges, whether or	nce benefits otherwise payable to me for not paid by insurance, and for all services	
authorize the above doctor and/or any provious ayment of benefits. I authorize the use of the	der or supplier of services in	n this office to releas	e the information required to secure the	
ignature of Responsible Party	organicate on an moutan	CO SUBIRIOSIVIIS.	Date	