			Patient #
			SS#/SIN
Patient Information	Date		
Name			Home Phone
Address			Home Phone State/ Zip/ Prov. P. C
Email			Cell Phone
Check Appropriate Box: ☐ Minor [☐ Divorced ☐ Wido	wed Separated
If Student, Name of School/College		City	State/ Full Part Prov Time Time
Patient or Parent/Guardian's Employer			Work Phone
Address	,	City	State/ 21p/ Prov P. C
Spouse or Parent/Guardian's Name	Work Phone		
Whom may we thank for referring you?			
Person to contact in case of emergency			Phone
Responsible Party			
Name of Person Responsible for this Accou			Relationship to Patient
Address			
Email			
Driver's License #	Birthaate	Financial Institu	LIOIL
Driver's License # Employer Is this person currently a patient in our of For your convenience, we offer the following □ Cash □ Personal Check	fice? Yes No methods of payment. Please	Work Phoneo check the option you prefer. Pays	SS#/SIN
Employer Is this person currently a patient in our of For your convenience, we offer the following	fice?	Work Phoneo check the option you prefer. Pays	SS#/SIN ment in full at each appointment. to discuss the office's payment policy.
Employer	fice? Yes No methods of payment. Please Credit Card VISA ation	Work Phoneo check the option you prefer. Pays	SS#/SIN ment in full at each appointment.
Employer Is this person currently a patient in our of proceeding the following of the following are convenience, we offer the following are cash Personal Check Insurance Information of Insured Birthdate	fice? Yes No methods of payment. Please Credit Card VISA ation SS#/SIN	Work Phone o check the option you prefer. Payn MasterCard □ I wish t	ment in full at each appointment. to discuss the office's payment policy. Relationship to Patient Date Employed
Employer Is this person currently a patient in our of proceeding the following of the following are convenience, we offer the following are cash Personal Check Insurance Information of Insured Birthdate	fice? Yes No methods of payment. Please Credit Card VISA ation SS#/SIN	Work Phone o check the option you prefer. Payn MasterCard □ I wish t	ment in full at each appointment. to discuss the office's payment policy. Relationship to Patient Date Employed
Employer Is this person currently a patient in our of for your convenience, we offer the following Cash Personal Check Insurance Information Name of Insured Birthdate Name of Employer Address of Employer	fice? Yes No methods of payment. Please Credit Card VISA ation SS#/SIN	Work Phone check the option you prefer. Payn MasterCard □ I wish t Union or Local # City	ment in full at each appointment. to discuss the office's payment policy. Relationship to Patient Date Employed Work Phone State/ Prov. P. C.
Employer Is this person currently a patient in our of for your convenience, we offer the following Cash Personal Check Insurance Information Name of Insured Birthdate Name of Employer Address of Employer	fice? Yes No methods of payment. Please Credit Card VISA ation SS#/SIN	Work Phone check the option you prefer. Payn MasterCard □ I wish t Union or Local # City	ment in full at each appointment. to discuss the office's payment policy. Relationship to Patient Date Employed Work Phone State/ Prov. P. C.
Employer Is this person currently a patient in our of proceeding the following of the following are convenience, we offer the following are cash Personal Check Insurance Information of Insured Birthdate	fice? Yes No methods of payment. Please Credit Card VISA ation SS#/SIN	Work Phone check the option you prefer. Payn MasterCard □ I wish t Union or Local # City	ment in full at each appointment. to discuss the office's payment policy. Relationship to Patient Date Employed Work Phone State/ Prov. P. C.
Employer Is this person currently a patient in our of for your convenience, we offer the following Cash Personal Check Insurance Information Name of Insured Birthdate Name of Employer Address of Employer	fice?	Work Phone check the option you prefer. Payn MasterCard □ I wish t Union or Local # City Group # City City	ment in full at each appointment. to discuss the office's payment policy. Relationship to Patient Date Employed Work Phone State/ Prov. Policy/ID # State/ State/ Prov. Pic.
Employer Is this person currently a patient in our of for your convenience, we offer the following Cash Personal Check Insurance Information Name of Insured Birthdate Name of Employer Address of Employer Insurance Company Ins. Co. Address	fice?	Work Phone check the option you prefer. Payn MasterCard □ I wish t Union or Local # City Group # City ye you used?	ment in full at each appointment. to discuss the office's payment policy. Relationship to Patient Date Employed Work Phone State/ Prov. Policy/ID # State/ State/ Prov. Pic.
Employer	fice?	Work Phone check the option you prefer. Payn MasterCard □ I wish t Union or Local # City Group # City_ ve you used? □ No IF YES, CON	ment in full at each appointment. to discuss the office's payment policy. Relationship to Patient Date Employed Work Phone State/ Prov. Policy/ID # State/ Prov.
Employer	fice?	Work Phone check the option you prefer. Payn MasterCard □ I wish t Union or Local # City Group # City_ ye you used? No IF YES, CON	ment in full at each appointment. to discuss the office's payment policy. Relationship to Patient Date Employed Work Phone State/ Prov. Policy/ID # State/ State/ Prov. Prov. Prov. Relationship
Employer	fice?	Work Phone check the option you prefer. Payor MasterCard □ I wish to Union or Local # City Group # City ve you used? □ No IF YES, COM	ment in full at each appointment. to discuss the office's payment policy. Relationship to Patient Date Employed Work Phone State/ Prov. Policy/ID # State/ Prov. Policy/ID # State/ Prov. Policy/ID # State/ Prov. Date Employed Max. annual benefit MPLETE THE FOLLOWING: Relationship to Patient Date Employed Work Phone
Employer	fice?	Work Phone check the option you prefer. Payor MasterCard □ I wish to Union or Local # City Group # City ve you used? De you used? Union or Local # Union or Local #	ment in full at each appointment. to discuss the office's payment policy. Relationship to Patient Date Employed Work Phone State/ Zip/ Prov. P. C. Policy/ID # State/ Zip/ Prov. P. C. Max. annual benefit MPLETE THE FOLLOWING: Relationship to Patient Date Employed Work Phone State/ Zip/ Prov. Zip/ Max. annual benefit
Employer	fice?	Work Phone check the option you prefer. Payn MasterCard □ I wish to Union or Local # City City ve you used? Union or Local # City	ment in full at each appointment. to discuss the office's payment policy. Relationship to Patient Date Employed Work Phone State/ Zip/ Prov. P. C. Policy/ID # State/ Zip/ Prov. P. C. Max. annual benefit MPLETE THE FOLLOWING: Relationship to Patient Date Employed Work Phone State/ Zip/ Prov. P. C. Policy/ID # Policy/ID # State/ Zip/ Prov. P. C. Relationship To Patient Date Employed Work Phone State/ Zip/ Prov. P. C. Policy/ID #
Employer	fice?	Work Phone check the option you prefer. Payn MasterCard □ I wish to Union or Local # City City ve you used? Union or Local # City	ment in full at each appointment. to discuss the office's payment policy. Relationship to Patient Date Employed Work Phone State/ Zip/ Prov. P. C. Policy/ID # State/ Zip/ Prov. P. C. Max. annual benefit MPLETE THE FOLLOWING: Relationship to Patient Date Employed Work Phone State/ Zip/ Prov. P. C. Max. annual benefit Plette THE FOLLOWING: Relationship to Patient Date Employed Work Phone State/ Zip/ Prov. P. C. Policy/ID # State/ Zip/ Prov. P. C.

Over Please

Physician	Office Phone			Date of Last Exam			
	Yes	No			Ye	es	N
1. Are you under medical treatment now?				vearing contact lenses?			L
2. Have you ever been hospitalized for any				lergic to or have you had any reactions to the foll		7	
surgical operation or serious illness within the last 5	years?			esthetics (e.g. Novocain) or any other Antibiotics		=	-
If yes, please explain				ugs		=	-
3. Are you taking any medication(s)				ites		7	
including non-prescription medicine?							
If yes, what medication(s) are you taking?			Iodine				
4. Have you ever taken Fen-Phen/Redux?				als (e.g. nickel, mercury, etc.)			L
5. Have you ever taken Fosamax, Boniva, Actonel or a				bber	L		L
medications containing bisphosphonates?	Ц		Other (pl	lease list) live a persistent cough or throat clearing not			
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?			12. Do you no	we a persistent cough or throat clearing not with a known illness (lasting more than 3 wee	be)2	7	
7. Do you use tobacco?			13. Women ((S): L		_
8. Do you use controlled substances?				u pregnant or think you may be pregnant:	·		E
9. Do you have or have you had any of the following?				u nursing?			Ē
9. Do you have or have you had any of the following?				u taking oral contraceptives?			
Yes No			Yes	No	Ye	ec	N
High Blood Pressure	Heart Disease			Chest Pains	-		
Heart Attack	Cardiac Pacemak			Easily Winded		ī	F
Rheumatic Fever	Heart Murmur			Stroke		=	F
Swollen Ankles	Angina			☐ Hay Fever / Allergies			F
Fainting / Seizures	Frequently Tired.			Tuberculosis			
Asthma	Anemia		percent.	Radiation Therapy			
Low Blood Pressure	Emphysema			Glaucoma			
Epilepsy / Convulsions	Cancer			Recent Weight Loss			
Leukemia	Arthritis			Liver Disease			
Diabetes	Joint Replacemen	t or Imp	lant	☐ Heart Trouble			
Kidney Diseases	Hepatitis / Jaund			Respiratory Problems			
AIDS or HIV Infection	Sexually Transmi	tted Dise	ease	☐ Mitral Valve Prolapse			
Thyroid Problem	Stomach Troubles	s / Ulcers	·	Other			
Dationt Dontal History	,						
Patient Dental History							
Name of Previous Dentist and Location				Date of Last Exam			
	Yes		0.0	6 - 1 - 1 - 1 - 2	Ye	es	N
1. Do your gums bleed while brushing or flossing?				ave frequent headaches?		4	
2. Are your teeth sensitive to hot or cold liquids/foods?				lench or grind your teeth?			
3. Are your teeth sensitive to sweet or sour liquids/foods				rite your lips or cheeks frequently? I ever had any difficult extractions		_	_
4. Do you feel pain to any of your teeth?				st?st			Г
 Bo you have any sores or tumps in or near your mot Have you had any head, neck or jaw injuries? 		H		ι ever had any prolonged bleeding			
7. Have you rear experienced any of the following				extractions?	F		Г
problems in your jaw?				ı had any orthodontic treatment?			F
Clicking				vear dentures or partials?			F
Pain (joint, ear, side of face)		П		te of placement			
Difficulty in opening or closing		П	15. Have you	ever received oral hygiene instructions			
Difficulty in chewing		П		g the care of your teeth and gums?	Г		Г
Difficulty in Gloring				ike your smile?			
. 1 15	1						
Authorization and Re	elease						
Authorization and Real Learning that I have read and understand the about 1 understand that providing incorrect information diagnosis and the records of any treatment or example and/or health practitioners. I authorize and require	ve information to can be dangerou mination rendere.	s to my	health. I author or my child dur	rize the dentist to release any informat ring the period of such Dental care to t	ion inclu hird part	ıdin tv p	
otherwise payable to me. I understand that my de for payment of all services rendered on my behalf X	ental insurance ca	rrier mo	y to pay affectly ay pay less than	the actual bill for services. I agree to	be respon	ısibi	le
				Date			
Signature of patient (or parent/guardian if minor)							
Signature of patient (or parent/guardian if minor)							