Welcome

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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.

Name		Patien	t Information)	
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City	Last Name	First Name	Initial	_ 000. 000. 11	17,117,13
Cell Phone	Address				
Cell Phone				Home Phone	13/6/61
Sex M F Age Birthdate Single Married Widowed Separated Divorced Patient Employed by Occupation Business Address Business Phone Business Email Whom may we thank for referring you? Notify in case of emergency Home Phone Cell Phone Business Phone Email Primary Insurance Person Responsible for Account Last Name First Name Initial Address (if different from patient) State Zip Cell Phone Email Person Responsible Employed by Docupation Business Phone Email Person Responsible Employed by Docupation Business Phone Business Phone Email Person Responsible Employed by Docupation Business Email Insurance Company Phone Insurance Email Insurance Email Group # Subscriber # Name of other dependents under this plan Additional Insurance Soc. Sec. # Insurance Imail Soc. Sec. # Name of other dependents under this plan Soc. Sec. # Additional Insurance Soc. Sec. # Insurance Email Soc. Sec. # Name of other dependents under this plan Soc. Sec. # Insurance Company Phone Insurance Email Soc. Sec. # Name of other dependents under this plan Phone Insurance Company Phone Insurance Email Soc. Sec. # Name of other dependents under this plan Phone Insurance Company Phone Insurance Company Phone Insurance Company Phone Insurance Company Phone Insurance Email Soc. Sec. # Name of other dependents under this plan Phone Insurance Company Phone Insurance Email Soc. Sec. # Name of other dependents under this plan Phone Name of other dependents under this plan Pho					12 B 7 B
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City	Relation to Patient	Birthdate		Soc. Sec. #	
Cell Phone	Address (if different from patient)			Home Phone	
Cell Phone	City		State	_ Zip	
Business Address					
Business Address	Person Responsible Employed by			Occupation	
Business Email					
Insurance Email Contract # Group # Subscriber #					
Insurance Email Contract # Group # Subscriber #	Insurance Company			Phone	
Additional Insurance Is patient covered by additional insurance?					
Additional Insurance Is patient covered by additional insurance?	Contract #	Group #		Subscriber #	
Additional Insurance Is patient covered by additional insurance?					
Is patient covered by additional insurance?		Appel Helico			
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Subscriber Name		Additi	onal Insuran	ce	
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Name of other dependents under this plan				Subscriber #	

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		Dent	al History			
What would you like us to do to	day2		,	are you in dental disc	omfort today?	
Former Dentist				are you in demandisc		
Dentist's Email						
Dentist's Email Date of last dental care						
				-1ays		
Check (✓) yes or no if you hav □ Y □ N Bad breath □ Y □ N Bleeding gums □ Y □ N Clicking or popping jaw	☐ Y ☐ N Food coll ☐ Y ☐ N Grinding	lection between to g or clenching te	eeth 🗆 Y 🗆 N F	ensitivity to hot	□ Y □ N Sens □ Y □ N Sores	itivity when biting s or growths in mouth
How often do you brush?		1341	F	loss?		
How do you feel about the appe	earance of your te	eth?				
Have you ever experienced an	adverse reaction	n during or in	conjunction wit	h a medical or denta	al procedure?	DY DN
Other information about your de	ental health or pre	evious treatme	nt			
		۸۸ - ۱:		,		
		Meald	cal History			
Physician's name				Phone		
Date of last visit		lave you had a	any serious illnes	ses or operations?	UY DN	
f yes, describe		D.N. If year	daaariba			
Are you currently under physicial Have you ever had a blood trans				datas		
lave you ever had a blood trans lave you ever taken Fen-Phen/		, ,	give approximate	dates		
Have you ever used a bisphosp			s include Fosamay	Actonal Atalyia Didro	and Boniva	
Vomen: Are you pregnant?		ng? 🗆 Y 🗀 l				
Check (🗸) yes or no whether y				n control pills? Y	U IV	
Y □ N AIDS/HIV Positive			ıg. □Y□N J	aw nain	□Y □N Sh	ingles
IY □ N Anaphylaxis	□Y □N Coug			idney disease or		ortness of breath
Y □ N Anemia	□Y □N Diabe	etes	m	alfunction	□Y □N Sk	
Y N Arthritis, Rheumatism	☐Y ☐N Epile			ver disease laterial allergies	□Y □N Sp	
□ Y □ N Artificial heart valves□ Y □ N Artificial joints	□Y□N Fainti	0	(1	atex, wool, metal,	□Y □N Str	
Y □ N Asthma	□Y □N Glaud	0		nemicals)		rgical implant
Y □ N Atopic (allergy prone)	□Y □N Head			itral valve prolapse ervous problems	or	ankles
Y □ N Back problems	□Y □N Hear		DY DN P			yroid disease or Ilfunction
IY □ N Blood disease IY □ N Cancer	☐ Y ☐ N Heart Describe	problems	Н	eart surgery	ma □Y □N Tol	
Y □ N Chemical dependency	□Y □N Hemo	ophilia/		sychiatric care	□Y □N Tor	
Y □ N Chemotherapy		rmal bleeding		apid weight gain or loss adiation treatment	□Y □N Tub	
IY □ N Circulatory problems	☐Y☐N Herpe			espiratory disease	DY DN Vo	
Y □ N Cortisone treatments	□Y □N High		□Y □N R	heumatic/Scarlet fever	UT UN Vei	nereal disease
patient currently taking any mo	edications? If yes	s, list all:	Does patie	nt have drug allergies	s? If yes, list al	l:
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			orization			
have reviewed the information of	on this questionna	aire, and it is a	ccurate to the be	est of my knowledge.	I understand t	hat this information
ill be used by the dentist to he will inform the dentist.	ip determine app	nopriate and n	ieaiiiiiui uental ti	eaunent. II there is a	any change in	my medical status,
authorize the insurance compervices rendered. I authorize the	any indicated or ne use of this sign	this form to p	pay to the dentis	st all insurance bene sions.	efits otherwise	payable to me for
authorize the dentist to releasesponsible for all charges wheth	se all information	necessary to			understand th	at I am financially
ignature					Date	
	in full at time of	of treatment,	unless prior a	rrangements have		
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