## Welcome to our Practice

PATIENT INFORMATION			Date
□ Mr. □ Mrs. □ Ms. □ Dr. First Name	M.I L	ast Name	Nickname
Sex:   Male Female Birth Date	Age Soc. Sec. #	E-I	mail
Street	Apt	_City	State Zip
Home Tel.() Cell.(_	)	Have you ever been a	patient of our practice?  Yes  No
Referred By FIRST NAME LAST NAME			patient of our practice?  Yes  No
Dentist		Medical Doctor	
Driver's Lic.# Last NAME  Neares	E at relative not living with yo	FIRST NAME	Tel.( )
			e: Cash Check Credit Card
In case of emergency, please contact		Tel. ()	
			Troidtion
WHO WILL BE RESPONSIBLE F			
☐ Self (If self, skip this section) ☐ Spouse ☐ Fath			T.17
FIRST NAME LAST NAME S.S.		Birth Date Age _	
Driver's Lic.# Em		CityBus.	
SPOUSE OR OTHER GUARANTO	lation		Birth Date
Street LAST NAME He		City	StateZip
	7,01.	Bus, Tel.(	) State Zip
INSURANCE INFORMATION			
		Jame and Address SCHOOL NAME	
	Vidow ☐ Single ☐ Le	egally Separated	ADDRESS
Employed:		Do you belong	state ZIP  I to a PPO or HMO?   Yes   No
PRIMARY INSURANCE COMPA	NY	SECONDARY INSUR	ANCE COMPANY
Insurance Type:   Dental   Medical		Insurance Type:   Dental	
			☐ Medical
Employer		Employer	□ Iviedical
Employer	STATE ZIP		
Employer	STATE ZIP	EmployerBus. AddressBus. Tel.()	CITY STATE ZIP
Employer	STATE ZIP  D. #	Bus. Address Bus. Tel.() Ins. Co. Name	CITY STATE ZIP
Employer	D. #	Bus. Address  Bus. Tel.()	CITY STATE ZIP PlanI.D. #
Employer	D. #	Bus. Address Bus. Tel.() Ins. Co. Name Address ADDRESS STATE ZIP	PlanI.D. #
Employer	D. #	Bus. Address Bus. Tel.() Ins. Co. Name Address ADDRESS  STATE Group #Group	PlanI.D. #I.D. #
Employer	D. #	Bus. Address Bus. Tel.() Ins. Co. Name Address ADDRESS  STATE ZIP Group # Gro Insured Party FIRST NAME LAST	PlanI.D. #  Tel.( )  Dup NameRelation
Employer	D. #	Bus. Address Bus. Tel.()  Ins. Co. Name  Address  Address  STATE  Group # FIRST NAME	PlanI.D. # Tel.()
Employer	D. #	Bus. Address Bus. Tel.() Ins. Co. Name  Address  Address  Address  STATE  Group # Gro  Insured Party  FIRST NAME  Sex:  M M F Birth Date  Street	PlanI.D. #  Tel.( )  Dup NameRelation
Employer  Bus. Address  Bus. Tel.( ) Plan  Ins. Co. Name  Address  ADDRESS  Tel.( ) CITY  Plan  Insured Party FIRST NAME  Sex: M M F Birth Date  State, Zip  City  State, Zip  Tel.( ) City  State, Zip  Tel.( ) City  Tel.( ) City	D. #	Bus. Address Bus. Tel.()  Ins. Co. Name  Address  Address  STATE  Group # FIRST NAME	PlanI.D. #  Tel.( )
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Employer  Bus. Address  Bus. Tel.( ) Plan  Ins. Co. Name  Address  ADDRESS  Tel.( ) CITY  Plan  Ins. Co. Name  Address  Finate  Group # Group Name  Insured Party First Name  Sex: □ M □ F Birth Date  Street  City  State, Zip  Tel.( ) City  State, Zip  DENTAL INFORMATION	tion	Bus. Address Bus. Tel.() Ins. Co. Name  Address  STATE  Group # Gro Insured Party FIRST NAME  Sex:  M  F Birth Date  Street  State, Zip  Du in pain?  Yes  No, For How L	Tel.()  NAME  City  Relation  S.S. #  City  Tel.()
Bus. Address Bus. Tel.( ) Plan Ins. Co. Name  Address  ADDRESS  Tel.( ) Plan  Ins. Co. Name  Address  STATE  Group # Group Name Insured Party FIRST NAME  Sex: M M F Birth Date  Street  City  State, Zip  Tel.( )  DENTAL INFORMATION  Reason for today's visit  Please indicate any of the following problems be Discomfort, clicking, or popping in jaw	tionAre your checking off the correct Lost / broken filling(s)	Bus. Address Bus. Tel.() Ins. Co. Name Address ADDRESS  STATE Group # Gro Insured Party FIRST NAME Sex: MM F Birth Date Street State, Zip  Du in pain? Yes No, For How Lesponding box: Stained teeth	PlanI.D. #
Bus. Address	D. #Are your checking off the corre  □ Lost / broken filling(s) □ Teeth grinding / clenchi	Bus. Address Bus. Tel.() Ins. Co. Name Address ADDRESS  STATE Group # Gro Insured Party FIRST NAME Sex: M M F Birth Date Street State, Zip  Ou in pain? Yes No, For How Lesponding box: Stained teeth ing Locking jaw	CITY STATE ZIP  Plan  I.D. #  Tel.()  Dup Name  Relation  S.S. #  City  Tel.()  Ong?  Difficulty closing jaw  Difficulty opening jaw
Bus. Address Bus. Tel.( ) Plan Ins. Co. Name	tionAre your checking off the correct Lost / broken filling(s)	Bus. Address Bus. Tel.( )   Ins. Co. Name Address ADDRESS  STATE ZIP Group # Gro Insured Party FIRST NAME Sex: M F Birth Date Street State, Zip  Ou in pain? Yes No, For How Lesponding box:  Stained teeth ing Locking jaw Bad breath	PlanI.D. #
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Bus. Address Bus. Tel.( ) Plan Ins. Co. Name  Address  ADDRESS  Tel.( ) Plan  Ins. Co. Name  Address  ADDRESS  Tel.( ) CITY  STATE  Group # Group Name Insured Party FIRST NAME  Sex: M F Birth Date  S.S. #  Street  City  State, Zip  Tel.( )  DENTAL INFORMATION  Reason for today's visit  Please indicate any of the following problems because in the company of the problems of the company of the problems of the company of the mouth Please indicate any of the mouth Prolonged bleeding from an injury / extraction	Are your checking off the corre Lost / broken filling(s) Teeth grinding / clenchi Ringing in ears Broken / chipped tooth	Bus. Address Bus. Tel.() Ins. Co. Name  Address  Address  ADDRESS  STATE  Group # Gro Insured Party FIRST NAME  Sex: M  F Birth Date  Street  State, Zip  Ou in pain? Yes No, For How Lesponding box:  Statined teeth ing  Locking jaw Bad breath Burning tongue / lips	CITY STATE ZIP  Plan  I.D. #  Tel.()  Dup Name  Relation  S.S. #  City  Tel.()  Ong?  Difficulty closing jaw  Difficulty opening jaw  Loose / shifting teeth Food caught between teeth
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Bus. Address Bus. Tel.( ) Plan Ins. Co. Name  Address  ADDRESS  Tel.( ) Plan  Ins. Co. Name  Address  ADDRESS  Tel.( ) CITY  STATE  Group # Group Name Insured Party FIRST NAME  Sex: M F Birth Date  S.S. #  Street  City  State, Zip  Tel.( )  DENTAL INFORMATION  Reason for today's visit  Please indicate any of the following problems because in the company of the mouth of the mou	Are your checking off the corre Lost / broken filling(s)  Teeth grinding / clenchi Ringing in ears Broken / chipped tooth Gum disease Other  Al x-rays  5 6 7 8 9 10 (best)	Bus. Address Bus. Tel.( )  Ins. Co. Name  Address  ADDRESS  STATE  Group # Gro  Insured Party FIRST NAME  Sex: M F Birth Date  Street  State, Zip  Ou in pain? Yes No, For How Lesponding box:  Stained teeth  Burning igw Bad breath Burning tongue / lips Toothache  Times a day you brush?  Would you like whiter teeth?	Plan

Are you in good	HISTOR	Υ				
The second of the second	health? 🗆 Ye	es 🗆 No	• Height _	Weight_	Are you under the care of	of a physician?  Yes  No
					prior to your dental treatment? • Yes	
Have you had a	ny illness, ope	eration,	or been hospi	talized in the past five y	rears? 🗆 Yes 🗅 No	
Have you ever ha	ad general ane	sthesia?	☐ Yes ☐ No	<ul> <li>Have you, or a family m</li> </ul>	nember, had any unusual or serious reaction	ons to general anesthesia? 🗆 Yes 🗅 No
Do you have, o					conditions, or procedures?	
Y N			YN	11 14 11	YN	YN
□ □ Rheumati				I health problems ms with immune system	□ □ Bleeding tendency □ □ Blood transfusion	<ul><li>Sexually transmitted diseases</li><li>Contagious diseases</li></ul>
□ □ Low blood			(possii	bly from med. / surg.)	□ □ Blood disorder	☐ ☐ Infectious mononucleosis
☐ ☐ Mitral valv			□ □ Delay	in healing	☐ ☐ Bruise easily	□ □ Swollen ankles
☐ ☐ Heart mur	220,0000		☐ ☐ Hay fe	ver / Sinus problems	☐ ☐ Eye disease / Glaucoma☐ ☐ ☐ Jaundice / Liver disease	□ □ Arthritis / Joint disease
☐ ☐ Heart atta				g apnea / CPAP	☐ ☐ Jadridice / Liver disease	☐ ☐ Prosthetic implant☐ ☐ Joint replacement
🗅 🗅 Irregular h			□ □ Respir	atory problems	☐ ☐ Gallbladder trouble	☐ ☐ Osteoporosis / Osteopenia
☐ ☐ Cardiac pa			□ □ Tubero		□ □ Fainting spells	□ □ Osteonecrosis
Damaged			Do you		<ul><li>□ □ Convulsions / Epilepsy</li><li>□ □ Stroke</li></ul>	☐ ☐ Stomach ulcers ☐ ☐ Tumor or growth
Pneumonia /	Bronchitis / Chron		If so, #	packs a day	☐ ☐ Thyroid trouble	☐ ☐ Cancer / Radiation / Chemotherapy
□ □ Chronic fa				use chewing tobacco	□ □ Diabetes	☐ ☐ Are you on a diet
☐ ☐ Trouble clim ☐ ☐ Anemia	bing 1-2 flights o	it stairs	A histo	ory of drug abuse ory of alcohol abuse	☐ ☐ Low blood sugar☐ ☐ Are you on dialysis	☐ Contact lenses
☐ ☐ Asthma			Abnor		☐ ☐ Kidney trouble	
MEDICAT	ION & A	LLED				
Are you now to		7776	GILS			
YN	ukiirg.		YN		Y N	YN
☐ ☐ Nerve pills	S			illers (including aspirin)	□ □ Muscle relaxers	□ □ Stimulants
☐ ☐ Diet pills			☐ ☐ Trangu	iilizers	☐ ☐ Insulin	□ □ Antidepressants
					herbal, or homeopathic products):	□ □ Blood thinners
MEDICATION	DOSAGE FREC	DENCY	MEDICATION	DOSAGE FREQUENCY	MEDICATION DOSAGE FREQUENCY	(Coumadin, Aspirin)  Are you taking, or have you
						ever taken, any bone density
						meds, or bisphosphonates,
						such as Fosamax, Boniva, Actonel, IV Zometa, Reclast,
						Xgeva, Prolia, or Aredia withir
Are you allergi	c to, or had a	reaction	on to:			the past 12 years.
Y N  Penicillin			Y N	le con	YN	YN
□ □ Sodium pente	othal / Valium / ot	her trang	□ □ Sulfa o		Local anesthetic (numbing med) Codeine or other narcotics	Amoxicillin
- Codium pont	odial / validiti / o	nor trang.	□ □ Eggs /		□ □ Sulfites	Do you have any known allergies
□ □ Soy						
□ □ Soy	other medica	ation or	antibiotic yo	u are allergic to:	Please list any allergies other than	drug allergies:
□ □ Soy	other medica	ation or	antibiotic yo	u are allergic to:		drug allergies:
□ □ Soy Please list any			antibiotic yo	ou are allergic to:	Please list any allergies other than	
Please list any	vomen only:	(Womer Consult	antibiotic yo n note: antibio t your physici	ou are allergic to:		ntrol pills
Please list any  1-4 below for v  1) Is there a pos	vomen only:	(Womer Consult	n note: antibiotic your physici	ou are allergic to:  otics (such as penicillin) an / gynecologist for as:  No	may alter the effectiveness of birth consistance regarding additional methods  2) Expected delivery date:	otrol pills. of birth control.)
Please list any	vomen only:	(Womer Consult	antibiotic yo n note: antibio t your physici	ou are allergic to:  otics (such as penicillin) an / gynecologist for as:  No	Please list any allergies other than may alter the effectiveness of birth consistance regarding additional methods	ntrol pills
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1-4 below for v  1) Is there a pos 3) Are you nursi  I certify that I have satisfaction. I will n	vomen only: ssibility of pre ing? e read and I und not hold my doc	(Womer Consult gnancy? derstand tor, or an	n note: antibide tyour physici  Yes  Yes  the questions a y other member	otics (such as penicillin) an / gynecologist for ass No No No above. I acknowledge that or of his / her staff, respons	may alter the effectiveness of birth consistance regarding additional methods  2) Expected delivery date:  4) Are you taking birth control pills:  my questions, if any, about the inquiries set ible for any errors or omissions that I have my riewed by	atrol pills. of birth control.)  Yes No forth above have been answered to my nade in the completion of this form.
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Please list any  1-4 below for v  1) Is there a pos 3) Are you nursi  I certify that I have satisfaction. I will n  X  Signature of pa  We make every ef manager depending any dental and/or m  Please remember to fixed allowances for balance not paid from the same series of the sa	ssibility of preing? e read and I und not hold my doc attent (Parent of gupon special medical insurance is procertain process.)	derstand tor, or an own the circumstate we will so consider the consideration of the consider	antibiotic your note: antibiotic your physicion yes	putics (such as penicillin) an / gynecologist for ass No No No above. I acknowledge that r of his / her staff, respons  X Rev  FEES & PA are. You can help by paying that of the charge for any pout the proper forms, but p of reimbursing the patient fercentage of the charge. It	may alter the effectiveness of birth consistance regarding additional methods  2) Expected delivery date:  4) Are you taking birth control pills:  my questions, if any, about the inquiries set ible for any errors or omissions that I have more eviewed by  AYMENTS g upon completion of each visit. Other arra procedure or surgery you may require will be lease complete the identifying information of for fees paid to the doctor and is not a substi	atrol pills. of birth control.)  Yes No  forth above have been answered to my nade in the completion of this form.  X  Date  Ingements can be made with our office e given to you upon request. If you have n this form.  Littute for payment. Some companies pay ble amount, co-insurance or any other is.
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