Patient Informantion				
		Loday	's Date	
Email Address Home	Sex DO ity Cell erred to us by:	B Age State Zipcoo Work	de	
Eme	rgency Information			
Name Address		Telephone		
Relationship to Patient				
Account Information Your Soc. Sec. # Your Employer Person Responsible for Account				
If Minor: Parent's Name Soc. Sec. #	DOB	Adress		
Mom				
Dad				

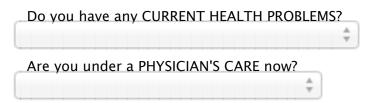
Dental Insurance Information		
PRIMARY COVERAGE	SECONDARY COVERAGE	
Patient's (insured) Name	Patient's (insured) Name	
Subscriber's Name	Subscriber's Name	
Subscriber's DOB	Subscriber's DOB	
Subscriber's SS #	Subscriber's SS #	
Insurance Co.	Insurance Co.	
Insurance Co. Address	Insurance Co. Address	
Subscriber's Employer	Subscriber's Employer	
Croup #	Group #	
Group #	Gloup #	
ID #	ID #	

MEDICAL INSURANCE INFORMATION		
Patient's (Insured) Name		
Subscriber's Name		
Subscriber's DOB		
Subscriber's SS #		
Insurance Co.		
Insurance Co. Address		
Subscriber's Employer		
Group #		
ID #		
It is important that I know about your Medical and Dental H		
Health. This information is strictly confidential and will not taking	be released to anyone. Thank you for	

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE: ■ Heart Disease or Attack ■ High Blood Pressure ■ Asthma Rheumatic Fever Mitral Valve Prolapse Diabetes Heart Pacemaker Artificial Joints (hip, knee) **■** Cortisone Medicine Stroke Ulcers Liver Disease Hepatitis A (Infectious) ■ Fever Blisters Drug Addiction ■ Glaucoma Nervousness ■ Venereal Disease (Syphilis, Gonorrhea, etc. Chemotherapy (Cancer, Leukemia) ■Tuberculosis (T.B.) Bruise Easily ■Allergies or Hives Hay Fever Arthritis Thyroid Disease ■ Cosmetic Surgery Pain in Jaw Joints Heart Murmur Angina Pectoris Artificial Heart Valve Congenital Heart Lesions Anemia Heart Surgery Aids/HIV positive ■ Kidney Trouble ■ Blood Transfusion Hepatitis B (Serum) Epilepsy or Seizures Hemophilia (Bleeding Problems) Psychiatric Treatment ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING? Aspirin Local Anesthetic Erythromycin ■ Nickel/other metals ■ Nitrous Oxide Codeine Penicillin Sulfa Are you aware of being allergic to any other medications or substances? if yes, please list: Is there any other Medical or Dental information that you feel I should know about?

PHONE Number:

FAMILY PHYSICIAN:



What are you under a physician's care now for?

Do you have any PINS or SCREWS in your joints, limbs, skull or anywhere in your body?

Where do you have PINS or SCREWS?

What MEDICATIONS are you currently taking?

Do you smoke?

For WOMEN: Are you PREGNANT, TRYING TO GET PREGNANT, ON BIRTH CONTROL?

HOW LONG SINCE you have seen a Dentist?
Last COMPLETE Dental Exam, Date:
What can we do for you TODAY?
Is your present dental health POOR?
Are you APPREHENSIVE or NERVOUS about dental treatment?
Are your teeth SENSITIVE to hot, cold, sweets, pressure?
Are you UNHAPPY with the APPEARANCE of your teeth?
Do you have DISCOLORED teeth that bother you?
Would you like your smile to LOOK BETTER or DIFFERENT?
Name of previous Dentist: City: State:
How do you feel about your teeth?

Is this your child's first visit to a dentist?	\$
Does your child eat between meals?	÷
Does your child brush teeth upon arising?	
Does your child brush teeth before going to bed?	A W
Have there been any injuries to their teeth, such as falls, blows, etc.?	<u> </u>
If so, explain:	
Has your child had any unfavorable dental experiences?	÷
Has your child ever received a local anesthetic or any form of anesthetic?	Å.
Has your child ever had nitrous oxide (laughing gas)?	
Has your child ever had a severe reaction to a local anesthetic or nitrous oxide?	, A
What can we do for you TODAY?	

	FAMILY HISTORY
Has any member of your family or in following:	nmediate relatives have or had a tendency to the
Early loss of teeth	*
Periodontal disease	*
High or low blood pressure	△
Bleeding tendency	△
Stroke	≜ ₩
Heart Disease	△ ▼
Diabetes	*
Over or underweight	≜ ₩
Cancer	≜
Stomah trouble or ulcers	★
Lung disease	A
Arthritis	★
Nervousness	♣
What made you choose our office?	
Tell us about your past dental experiences?	
Additional info that you would like to share with us:	

Do you or have you had headaches?	÷
Do you have pain in jaw joints?	*
Do you have noises in your jaw joints?	*
Do you have neck pain?	*
Do you have broken/sensitive teeth?	*
Do you doze off while reading, watching tv, sitting inactive or in a public place?	‡
Has anyone noticed that you stopped breathing during your sleep?	*

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs.

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