## Welcome

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.

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Notify in case of emergency Home Phone Cell Phone Business Phone Email Person Responsible for Account Relation to Patient Birthdate Soc. Sec. # Address (if different from patient) Home Phone City State Zip Citl Phone Birthdate Business Phone Business Address Business Phone Business Address Business Phone Business Address Business Phone Business Address Business Phone Business Email Insurance Company Phone Insurance Email Subscriber # Subscriber # Subscriber mane Relation to Patient Birthdate Midress (if different from patient) Soc. Sec. # Zity State Zip Home Phone Eightent covered by additional insurance? Yes No Subscriber Name Relation to Patient Birthdate City State Zip Home Phone Zity State Zip Home Phone Business Phone					-
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Email       Person Responsible for Account       Iast Name       First Name       In         Relation to Patient       Birthdate       Soc. Sec. #       In         Address (if different from patient)       Birthdate       Soc. Sec. #       In         City       State       Zip       In         City       State       Zip       In         City       State       Zip       In         City       State       Zip       In         Company       Business Address       Business Phone       Insurance         Business Email       Insurance       Group #       Subscriber #       Insurance         Insurance Company       Phone       Insurance       Insurance       Insurance         Insurance Email       Group #       Subscriber #       Insurance       Insurance       Insurance         Insurance Company       Phone       Insurance       I					
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Address (if different from patient)		Last Name		First Name	Initial
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CityState Zip Cell Phone Email Person Responsible Employed byOccupation Business Address Business Phone Business Email Insurance Company Phone Insurance Email Contract # Group # Subscriber # Name of other dependents under this plan Additional Insurance Subscriber Mame Relation to Patient Birthdate Subscriber Name Relation to Patient Birthdate City State Zip Home Phone Cell Phone Email Dell Phone Email Business Email Subscriber Employed by Business Phone Business Email Insurance Company Phone Subscriber Employed by Phone Business Email Phone Subarate Email Phone	Address (if different from patient)			Home Phone	
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Business Address Business Phone Business Email Phone Insurance Email Group # Subscriber # Name of other dependents under this plan Name of other dependents under this plan Additional Insurance Is patient covered by additional insurance?  I Yes I No Subscriber Name Relation to Patient Birthdate Address (if different from patient) Soc. Sec. # City State Zip Home Phone City State Zip Home Phone Subscriber Employed by Business Phone Business Email Insurance Company Phone Phone				Occupation	
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Insurance Company Phone Insurance Email Group # Subscriber # Name of other dependents under this plan Additional Insurance Is patient covered by additional insurance?  Yes  No Subscriber Name Relation to Patient Birthdate Address (if different from patient) Soc. Sec. # City State Zip Home Phone City State Zip Home Phone Cell Phone Email Subscriber Employed by Business Phone Business Email Insurance Company Phone	Business Email				
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Name of other dependents under this plan	Contract #	Group #		Subscriber #	
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Patient Information

## **Dental History**

	Are you in dental discomfort today	11
Date of	last x-rays	
ad problems with any of the following:		
□ Y □ N Food collection between teeth	🗆 Y 🗔 N Periodontal treatment	I Y IN Sensitivity to sweets
Y IN Grinding or clenching teeth	□ Y □ N Sensitivity to cold	🗅 Y 🗅 N Sensitivity when biting
	Y IN Sensitivity to hot	□ Y □ N Sores or growths in mout
	Floss?	
erse reaction during or in conjunction wit	h a medical or dental procedure?	אם אב
r nearr or previous rearrient		and the second
Med	ical History	
		2
are? 🗅 Y 🗅 N If yes, describe		
on? 🗅 Y 🗅 N 🛛 If yes, give approximate	e dates	and the second
te medication? Brand names include Fosam:	ax, Actonel, Atelvia, Didronel and Boni	va. 🗆 Y 🖵 N
🗆 N Nursing? 🗀 Y 🗀 N Taking birt	h control pills? 🗆 Y 🗔 N	
week compared a second contractions	h control pills? UY UN	
N Nursing? □ Y □ N Taking birt have had any of the following: □ Y □ N Cough, persistent	h control pills? UY UN	□ Y □ N Shingles
have had any of the following:	<ul> <li>Y □ N Jaw pain</li> <li>Y □ N Kidney disease or</li> </ul>	
have had any of the following:	□ Y □ N Jaw pain □ Y □ N Kidney disease or malfunction	□ Y □ N Shingles □ Y □ N Shortness of breath □ Y □ N Skin rash
have had any of the following: Y N Cough, persistent Y N Cough up blood	<ul> <li>Y □ N Jaw pain</li> <li>Y □ N Kidney disease or malfunction</li> <li>Y □ N Liver disease</li> </ul>	<ul> <li>Y □ N Shingles</li> <li>Y □ N Shortness of breath</li> <li>Y □ N Skin rash</li> <li>Y □ N Spina Bifida</li> </ul>
have had any of the following: Y N Cough, persistent Y N Cough up blood Y N Diabetes	<ul> <li>Y □ N Jaw pain</li> <li>Y □ N Kidney disease or malfunction</li> <li>Y □ N Liver disease</li> <li>Y □ N Material allergies</li> </ul>	<ul> <li>Y □ N Shingles</li> <li>Y □ N Shortness of breath</li> <li>Y □ N Skin rash</li> <li>Y □ N Spina Bifida</li> <li>Y □ N Stroke</li> </ul>
have had any of the following: Y N Cough, persistent Y N Cough up blood Y N Diabetes Y N Epilepsy	<ul> <li>Y □ N Jaw pain</li> <li>Y □ N Kidney disease or malfunction</li> <li>Y □ N Liver disease</li> </ul>	<ul> <li>Y □ N Shingles</li> <li>Y □ N Shortness of breath</li> <li>Y □ N Skin rash</li> <li>Y □ N Spina Bifida</li> <li>Y □ N Stroke</li> <li>Y □ N Surgical implant</li> </ul>
have had any of the following: Y N Cough, persistent Y N Cough up blood Y N Diabetes Y N Epilepsy Y N Fainting	<ul> <li>Y N Jaw pain</li> <li>Y N Kidney disease or malfunction</li> <li>Y N Liver disease</li> <li>Y N Liver disease</li> <li>Y N Material allergies (latex, wool, metal, chemicals)</li> </ul>	Y       N       Shingles         Y       N       Shortness of breath         Y       N       Skin rash         Y       N       Spina Bifida         Y       N       Stroke         Y       N       Surgical implant         Y       N       Swelling of feet
have had any of the following: Y N Cough, persistent Y N Cough up blood Y N Diabetes Y N Epilepsy Y N Fainting Y N Food allergies Y N Glaucoma Y N Headaches	<ul> <li>Y N Jaw pain</li> <li>Y N Kidney disease or malfunction</li> <li>Y N Liver disease</li> <li>Y N Liver disease</li> <li>Y N Material allergies (latex, wool, metal, chemicals)</li> </ul>	Y N Shingles Y N Shortness of breath Y N Skin rash Y N Spina Bifida Y N Stroke Y N Surgical implant Y N Swelling of feet or ankles
have had any of the following: Y N Cough, persistent Y N Cough up blood Y N Diabetes Y N Epilepsy Y N Fainting Y N Food allergies Y N Glaucoma Y N Headaches Y N Heat murmur	<ul> <li>Y N Jaw pain</li> <li>Y N Kidney disease or malfunction</li> <li>Y N Liver disease</li> <li>Y N Material allergies (latex, wool, metal, chemicals)</li> <li>Y N Mitral valve prolapse</li> <li>Y N Nervous problems</li> <li>Y N Pacemaker/</li> </ul>	Y       N       Shingles         Y       N       Shortness of breath         Y       N       Skin rash         Y       N       Spina Bifida         Y       N       Stroke         Y       N       Surgical implant         Y       N       Swelling of feet
have had any of the following: Y N Cough, persistent Y N Cough up blood Y N Diabetes Y N Epilepsy Y N Fainting Y N Food allergies Y N Glaucoma Y N Headaches Y N Heart murmur Y N Heart problems	<ul> <li>Y N Jaw pain</li> <li>Y N Kidney disease or malfunction</li> <li>Y N Liver disease</li> <li>Y N Material allergies (latex, wool, metal, chemicals)</li> <li>Y N Mitral valve prolapse</li> <li>Y N Nervous problems</li> <li>Y N Pacemaker/ Heart surgery</li> </ul>	<ul> <li>Y N Shingles</li> <li>Y N Shortness of breath</li> <li>Y N Skin rash</li> <li>Y N Spina Bifida</li> <li>Y N Stroke</li> <li>Y N Surgical implant</li> <li>Y N Swelling of feet or ankles</li> <li>Y N Thyroid disease or</li> </ul>
have had any of the following: Y N Cough, persistent Y N Cough up blood Y N Diabetes Y N Epilepsy Y N Fainting Y N Food allergies Y N Glaucoma Y N Headaches Y N Heat murmur Y N Heart problems Describe	<ul> <li>Y N Jaw pain</li> <li>Y N Kidney disease or malfunction</li> <li>Y N Liver disease</li> <li>Y N Liver disease</li> <li>Y N Material allergies (latex, wool, metal, chemicals)</li> <li>Y N Mitral valve prolapse</li> <li>Y N Nervous problems</li> <li>Y N Pacemaker/ Heart surgery</li> <li>Y N Psychiatric care</li> </ul>	<ul> <li>Y N Shingles</li> <li>Y N Shortness of breath</li> <li>Y N Skin rash</li> <li>Y N Spina Bifida</li> <li>Y N Stroke</li> <li>Y N Surgical implant</li> <li>Y N Swelling of feet or ankles</li> <li>Y N Thyroid disease or malfunction</li> <li>Y N N Tobacco habit</li> </ul>
have had any of the following: Y N Cough, persistent Y N Cough up blood Y N Diabetes Y N Epilepsy Y N Fainting Y N Food allergies Y N Glaucoma Y N Headaches Y N Heat murmur Y N Heart murmur Y N Heart problems Describe Y N Hemophilia/	<ul> <li>Y N Jaw pain</li> <li>Y N Kidney disease or malfunction</li> <li>Y N Liver disease</li> <li>Y N Liver disease</li> <li>Y N Material allergies (latex, wool, metal, chemicals)</li> <li>Y N Mitral valve prolapse</li> <li>Y N Nervous problems</li> <li>Y N Pacemaker/ Heart surgery</li> <li>Y N Psychiatric care</li> <li>Y N Rapid weight gain or loss</li> </ul>	<ul> <li>Y N Shingles</li> <li>Y N Shortness of breath</li> <li>Y N Skin rash</li> <li>Y N Spina Bifida</li> <li>Y N Stroke</li> <li>Y N Surgical implant</li> <li>Y N Swelling of feet or ankles</li> <li>Y N Thyroid disease or malfunction</li> <li>Y N N Tobacco habit</li> </ul>
have had any of the following: Y N Cough, persistent Y N Cough up blood Y N Diabetes Y N Epilepsy Y N Fainting Y N Food allergies Y N Glaucoma Y N Headaches Y N Heart murmur Y N Heart murmur Y N Heart problems Describe Y N Hemophilia/ Abnormal bleeding	<ul> <li>Y N Jaw pain</li> <li>Y N Kidney disease or malfunction</li> <li>Y N Liver disease</li> <li>Y N Liver disease</li> <li>Y N Material allergies (latex, wool, metal, chemicals)</li> <li>Y N Mitral valve prolapse</li> <li>Y N Nervous problems</li> <li>Y N Pacemaker/ Heart surgery</li> <li>Y N Psychiatric care</li> <li>Y N Rapid weight gain or loss</li> <li>Y N Radiation treatment</li> </ul>	<ul> <li>Y N Shingles</li> <li>Y N Shortness of breath</li> <li>Y N Skin rash</li> <li>Y N Spina Bifida</li> <li>Y N Stroke</li> <li>Y N Surgical implant</li> <li>Y N Swelling of feet or ankles</li> <li>Y N Thyroid disease or malfunction</li> <li>Y N Tobacco habit</li> <li>Y N N Tonsillitis</li> </ul>
have had any of the following: Y N Cough, persistent Y N Cough up blood Y N Diabetes Y N Epilepsy Y N Fainting Y N Food allergies Y N Glaucoma Y N Headaches Y N Heat murmur Y N Heart murmur Y N Heart problems Describe Y N Hemophilia/	<ul> <li>Y N Jaw pain</li> <li>Y N Kidney disease or malfunction</li> <li>Y N Liver disease</li> <li>Y N Liver disease</li> <li>Y N Material allergies (latex, wool, metal, chemicals)</li> <li>Y N Mitral valve prolapse</li> <li>Y N Nervous problems</li> <li>Y N Pacemaker/ Heart surgery</li> <li>Y N Psychiatric care</li> <li>Y N Rapid weight gain or loss</li> </ul>	<ul> <li>Y N Shingles</li> <li>Y N Shortness of breath</li> <li>Y N Skin rash</li> <li>Y N Spina Bifida</li> <li>Y N Stroke</li> <li>Y N Stroke</li> <li>Y N Surgical implant</li> <li>Y N Swelling of feet or ankles</li> <li>Y N Thyroid disease or malfunction</li> <li>Y N Tobacco habit</li> <li>Y N Tobreculosis</li> </ul>
	Phone Date of	ad problems with any of the following:   Y   Y   Y   N Food collection between teeth   Y   Y   N Grinding or clenching teeth   Y   Y   N Grinding or clenching teeth   Y   Y   N Sensitivity to cold   Y   N Loose teeth or broken fillings   Y   N Loose teeth or broken fillings   Y   N Sensitivity to hot   Floss?   Ince of your teeth? Floss? Ince of your teeth? Ince of your teeth? Medical History Phone Phone Phone Phone Phone Ince? Y N If yes, describe Ince? Y N If yes, give approximate dates Ince

## Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_

Payment is due in full at time of treatment, unless prior arrangements have been approved.

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FM-04573

Date