Patient Information	(	Dental	Insurance	
Date	MA			
SS/HIC/Patient ID #			or this account?	
			nt	
Patient Name				
		oup #		
First Name		patient covered by	additional insurance?  Yes	□ No
Address	Sul	bscriber's Name_		
E-mail	Birt	thdate	SS#	
City	Rel	lationship to Patie	nt	
State Zip				
Sex  M F Age				
Birthdate				
☐ Married ☐ Widowed ☐ Single	Lo	SIGNMENT AND RE ertify that I, and/	or my dependent(s), have insurar	nce coverage with
- Introduce of the second seco			and	assign directly to
☐ Separated ☐ Divorced ☐ Partnered for		Name of Ins	urance Company(ies)	
Patient Employer/School			to me for services rendered. I und	
Occupation	fina	ncially responsible for	or all charges whether or not paid by in	
Employer/School Address			on all insurance submissions.	
			st may use my health care informatio above-named Insurance Company(ies)	
Employer/School Phone ()			payment for services and determining or related services. This consent will e	
Spouse's Name	trea		eted or one year from the date signed	
Birthdate		Signature of Patie	ent, Parent, Guardian or Personal Rep	recentative
		olgridiano or r din	on, raion, adardar or rotoonarriop	resentative
SS#		Please print name of	Patient, Parent, Guardian or Personal	Representative
Spouse's Employer		5		
Whom may we thank for referring you?		Date	Relationship t	o Patient
Phone Numbers				
00	W. E.			
	Work ()	Ext	Alt. Phone ()	
	Best time and place to reach you			
IN CASE OF EMERGENCY, CONTACT (Specify se				
Name	Relation	onship		
Phone ()	Alt. Ph	one ()		
Dental History				
Reason for today's visit	Burning sensation on tongue Chew on one side of mouth	☐ Yes ☐ No ☐ Yes ☐ No	Mouth breathing  Mouth pain, brushing	☐ Yes ☐ No
	Cigarette, pipe, or cigar smoking		Orthodontic treatment	☐ Yes ☐ No ☐ Yes ☐ No
Former Dentiet	Clicking or popping jaw	☐ Yes ☐ No	Pain around ear	☐ Yes ☐ No
	Dry mouth	☐ Yes ☐ No	Periodontal treatment	☐ Yes ☐ No
I liate of last dental visit	Fingernail biting	☐ Yes ☐ No	Sensitivity to cold	☐ Yes ☐ No
	Food collection between the teeth Foreign objects	☐ Yes ☐ No	Sensitivity to heat Sensitivity to sweets	☐ Yes ☐ No ☐ Yes ☐ No
·	Grinding teeth	Yes No	Sensitivity when biting	Yes No
	Gums swollen or tender	☐ Yes ☐ No	Sores or growths in your mouth	
	Jaw pain or tiredness	☐ Yes ☐ No	How often do you floss?	
	Lip or cheek biting	☐ Yes ☐ No		
Blisters on lips or mouth Yes No	Loose teeth or broken fillings	☐ Yes ☐ No	How often do you brush?	

**Dental Registration and History** 

Physician's Name Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva.   ves   No   Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva.   ves   No   Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva.   ves   No   Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva.   ves   No   Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva.   ves   No   Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva.   ves   No   Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva.   ves   No   Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva.   ves   No   Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva.   ves   No   Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva.   No   Have you ever used a bisphosphonate medication?   ves   No   Head Bonival   ves   No   Glaucoma   ves   No   Hard Turnur   ves   No   Shorthess of Breath   ves   No   Head Troblems   ves   No   Shorthess of Breath   ves   No   Head Troblems   ves   No   Shorthess of Breath   ves   No   Head Troblems   ves   No   Shorthess of Breath   ves   No   Head Troblems   ves   No   Shorthess of Breath   ves   No   Head Troblems   ves   No   Shorthess of Breath   ves   No   Head Troblems   ves   No   Shorthess of Breath   ves   No   Head Troblems   ves   No   Shorthess of Breath   ves   No   Head Troblems   ves   No   Shorthess of Breath   ves   No   Head Troblems   ves   No   Shorthess of Breath   ves   No   Head Troblems   ves   No   Shorthess o	sician's Name e you ever used a bisphospho e you ever taken any of the gi							
Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brar names of phentermine), Pondimin (fenturamine) and Redux (descributamine), 19 (% by No Place a mark on "yes" or "no" to indicate if you have had any of the following: AIDS/HIV AIDS/HIV AIDS/HIV ARAPHINA, Rheumatism   Yes   No   Fainting or dizziness   Yes   No   Respiratory Disease   Yes Arthritis, Rheumatism   Yes   No   Fainting or dizziness   Yes   No   Rheumatic Fever   Yes Arthritis, Rheumatism   Yes   No   Glaucoma   Yes   No   Shortness of Breath   Yes Arthritis, Rheumatism   Yes   No   Headfaches   Yes   No   Shortness of Breath   Yes Arthritical Joints   Yes   No   Head Hurmur   Yes   No   Skin Rash   Yes   No   Heath Froblems   Yes   No   Skin Rash   Yes   No   Heath Froblems   Yes   No   Shortness of Breath   Yes   No   Heath Froblems   Yes   No   Skin Rash   Yes   No   Heath Froblems   Yes   No   Shortness of Breath   Yes   No   Heath Froblems   Yes   No   Shortness of Breath   Yes   No   Yes   No   Yes   No   Yes   No   Shortness of Breath   Yes   No   Yes   No   Yes   No   Yes   No   Yes   No   Shortness of Breath   Yes   No   Yes   No   Yes   No   Shortness of Breath   Yes   No   Shortness of Breath   Yes   No   Shortness of Breath   Yes   No   Shortness of Breath   Yes   Yes   No   Shortness of Breath   Yes   Yes   No   Throblems   Yes   No   Throblems   Yes   No	e you ever used a bisphosphoe you ever taken any of the gr							
Have you ever taken any of the group of drugs collectively referred to as "ten-phen?" These include combinations of Ionimin, Adipex, Fastin (brar names of pheniemine), Pondimin (tenfluramine) and Redux (dexfenfluramine). Yes No No Place a mark on Yes' or 'no' to indicate if you have had any of the following:  AIDS/HIV	e you ever taken any of the gr							
names of phentermine), Pondrimin (fentfuramine) and Redux (dexfentfuramine).								
Anemia		n (fenfluramine) and	d Redux (dexfenfluramin	e). 🗌 Yes 🔀 No	combinations of Ionimin, Adipex,	Fastin (brand		
Anemia					Respiratory Disease	☐ Yes ☐ No		
Arthritis, Rheumatism								
Artificial Joints		and the second s			Scarlet Fever	☐ Yes ☐ No		
Asthma   Yes   No   Heart Problems   Yes   No   Skin Rash   Yes   Back Problems   Yes   No   Hepatitis Type   Yes   No   Special Diet   Yes   No   Herpes   Yes   No   Stroke   Yes   No   Swollen Feet or Ankles   Yes   No   Swollen Neck Glands   Yes   No   Thyroid Problems   Yes   No   Tuberculosis   Yes   No   Yes   No   Nervous Problems   Yes   No   Ulcer   Yes   Yes   No   Nervous Problems   Yes   No   Yes   No   Yes   No   Nomen:   Yes   No   Radiation Treatment   Yes   No   Nomen:   Are you nursing?   Yes   No   Nomen:   Are you nursing?   Yes   No   Nomen:   Are you nursing?   Yes   No   Nomen:   Aspirin   Local Anesthetic   Barbiturates (Sleeping pills)   Penicillin   Codeine   Sulfa   Pharmacy Name   Indian   Indian	icial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Shortness of Breath	Yes No		
Back Problems   Yes   No	icial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No		
Bleeding abnormally, with extractions or surgery   Yes   No   High Blood Pressure   Yes   No   Stroke   Yes   Stroke   Yes   No   Thuror or growth on head   Yes   Yes   No   Thuror or growth on head   Or neck   Yes   Yes   Yes   Yes   Yes   No   Ye	ıma	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No		
extractions or surgery	k Problems	☐ Yes ☐ No	Hepatitis Type	Yes				
Blood Disease								
Cancer	W COM							
Chemical Dependency								
Chemotherapy   Yes   No   Liver Disease   Yes   No   Tuberculosis   Yes   Circulatory Problems   Yes   No   Low Blood Pressure   Yes   No   Tumor or growth on head   Or neck   Yes   No   Or neck		П			Social Control of the			
Circulatory Problems								
Congenital Heart Lesions						_ 100 _ 110		
Cortisone Treatments	•			= = =	And the Committee of th	☐ Yes ☐ No		
Diabetes				☐ Yes ☐ No	Ulcer	☐ Yes ☐ No		
Emphysema	gh, persistent or bloody	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No		
Do you wear contact lenses?	petes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No		
Women: Are you pregnant?   Yes   No   Due date   Are you nursing?   Yes   No   Taking birth control pills?   Yes   No    Medications  List any medications you are currently taking and the correlating diagnosis:	physema	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No				
Are you pregnant?   Yes   No   Due date   Are you nursing?   Yes   No   Taking birth control pills?   Yes   No      Medications   Medications	ou wear contact lenses?	☐ Yes ☐ No						
Taking birth control pills?   Yes   No    Medications								
Medications  List any medications you are currently taking and the correlating diagnosis:    Aspirin		3 ( ) ( )	Oue date	Are you r	nursing?   Yes   No			
List any medications you are currently taking and the correlating diagnosis:    Aspirin	king birth control pills?   Yes	S   NO						
diagnosis:    Barbiturates (Sleeping pills)   Penicillin     Codeine   Sulfa     Iodine   Other     Latex     Updates (To be filled in at future appointments)  Has there been any change in your health since your last dental appointment?   Yes   No  For what conditions?	Medications			$\mathbb{C}$	Allergies			
Barbiturates (Sleeping pills) Penicillin  Codeine Sulfa  I lodine  Phone () Latex  Updates (To be filled in at future appointments)  Has there been any change in your health since your last dental appointment? Yes No  For what conditions?			☐ Aspirin	☐ Local Anesth	netic			
Pharmacy Name     lodine   Other   Phone () _ Latex    Updates (To be filled in at future appointments)  Has there been any change in your health since your last dental appointment?   Yes   No  For what conditions?	110313.			☐ Barbiturates (Sleep	oing pills) Penicillin			
Phone () Latex  Updates (To be filled in at future appointments)  Has there been any change in your health since your last dental appointment? Yes No  For what conditions?				☐ Codeine	☐ Sulfa			
Phone ()	Di como N			□ lodine	☐ Other			
Updates (To be filled in at future appointments)  Has there been any change in your health since your last dental appointment?   Yes   No  For what conditions?	Pharmacy Name			□ Lateu				
Has there been any change in your health since your last dental appointment?   Yes   No  For what conditions?	Phone ()							
For what conditions?	ile ()	filled in at fut	ure appointments					
For what conditions?	•	mica in at fut						
	Updates (To be		ur last dental appointme	nt? ☐ Yes ☐ No				
Are you taking any new medications? If so, what?	Updates (To be sthere been any change in you	our health since yo						
Patient's Signature Date	Updates (To be sthere been any change in you what conditions?	our health since yo						
	Updates (To be sthere been any change in you what conditions?	our health since yo	If so, what?					
Doctor's Signature Date	Updates (To be sthere been any change in you what conditions?  you taking any new medication ient's Signature	our health since yo	If so, what?		Date			
	Updates (To be sthere been any change in you what conditions?	our health since yo	If so, what?		Date			
Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No	Updates (To be sthere been any change in you what conditions?	our health since yo	If so, what?		Date			
For what conditions?	Updates (To be sthere been any change in you what conditions?	our health since yo	If so, what?		Date			
Are you taking any new medications? If so, what?	Updates (To be sthere been any change in you what conditions?  you taking any new medication item's Signature  ctor's Signature  sthere been any change in you	our health since yo	If so, what? ur last dental appointme	nt?	Date Date			
Patient's Signature Date	Updates (To be sthere been any change in you what conditions?  you taking any new medication item's Signature  ctor's Signature  sthere been any change in you what conditions?	our health since yo	If so, what? ur last dental appointme	nt?	DateDate			
Doctor's SignatureDate	Updates (To be sthere been any change in you what conditions?  you taking any new medication ient's Signature ctor's Signature sthere been any change in you what conditions?  you taking any new medication you what any new medication.	our health since you	If so, what? ur last dental appointme	nt? □ Yes □ No	DateDate			
	Updates (To be sthere been any change in you what conditions?	our health since yo	If so, what? ur last dental appointme	nt? □ Yes □ No	Date			