Welcome



Patient Information

Patient Name	SS/HIC/Patient I		Respiratory Urse Eneumatic Final	ori [] eavi
First Name Middle Initial	Patient Name			
First Name Middle Initial Address		Las	st Name	Yes Divis
City	OM ID BOY D	First Name		Middle Initial
City	Address		Special Diet	old Classy (
State Zip	City			
Sex M F Birthdate Age Married Widowed Single Minor Separated Divorced Partnered for years Occupation Patient Employer/School Employer/School Address Employer/School Phone () Spouse's Name Birthdate Ss# Spouse's Employer	State	289ADA 2532	Zip	ON TO BEAL
Sex M F Birthdate Age Married Widowed Single Minor Separated Divorced Partnered for years Occupation Patient Employer/School Employer/School Address Employer/School Phone () Spouse's Name Birthdate SS# Spouse's Employer	E-mail	/	Thyroid Problem	ow [] ser [
☐ Separated ☐ Divorced ☐ Partnered for years Occupation Patient Employer/School Employer/School Address Employer/School Phone () Spouse's Name Birthdate Spouse's Employer				
Occupation Patient Employer/School Employer/School Address Employer/School Phone () Spouse's Name Birthdate SS# Spouse's Employer	Married	Widowed	Single	Minor
Occupation Patient Employer/School Employer/School Address Employer/School Phone () Spouse's Name Birthdate SS# Spouse's Employer	□ Separated	Divorced	☐ Partnered for	years
Patient Employer/School Employer/School Address Employer/School Phone () Spouse's Name Birthdate Spouse's Employer	Occupation	9	Venerall Disease	
Employer/School Address Employer/School Phone () Spouse's Name Birthdate Spouse's Employer	Patient Employe	r/School	Weight Loss, uni	old Dash (
Employer/School Phone () Spouse's Name Birthdate SS# Spouse's Employer				
Spouse's Name				
Spouse's Name	Employer/Schoo	I Phone ()	Are you nursing	and the same of th
BirthdateSS#Spouse's Employer				
SS#Spouse's Employer				
Spouse's Employer				1011

Thank you for trusting us with your health care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

-Air-			-ai			
Patient In	nformatio	n	D	Dent	tal Insurance	
Date		W	ho is resp	onsible for	r this account?	Pleca a made on Sp
Date		PALL SAY LE	elationship	to Patien	t_0H [] ## []) . VHERDIA
SS/HIC/Patient ID #		DV/17 83			ON [] ser []	
Patient Name	ast Name				es No	wfeV heatt falcilina
	ast Name		51,127931			
	Skin Pash	Middle Initial Is	patient co	overed by a	additional insurance? Yes	No
Address	Special Diet				AV EL PAYEL	Red Problems
City	Stroke Swgten Feet of A	Bi	rthdate	Parpet	SS#	Bleeding abnormal
State	Zip	Re	,		t	Blood Disease
E-mail	Thyroid Problems	10000			□ Yes □ No	Cancellos Proceeds
Sex M F Birthdate		Age Gi	roup #	G yentak	DALE SOLE AND	en myeur momentue Ones territors en G
☐ Married ☐ Widowed		AS	SSIGNMEN	T AND REL	EASE	
		and the said the said the	certify tha	at I, and/o	or my dependent(s), have insura	nce coverage with
☐ Separated ☐ Divorced		- DATE SEATE TO THE SEATE -	N	ame of Insu	irance Company(ies)	assign directly to
Occupation						Cough, persistent (
Patient Employer/School	Weight Loss, uneschool				me for services rendered. I understan	
Employer/School Address		res			es whether or not paid by insurance. I ance submissions.	authorize the use of
			,			nd may disalose such
THE THE PARTY OF T	.Youisiun you eu	inf	formation to	the above	t may use my health care information at -named Insurance Company(ies) and	their agents for the
Employer/School Phone (_)	pu	rpose of ob	otaining payr ble for relate	ment for services and determining insu ed services. This consent will end when	rance benefits or the my current treatment
Spouse's Name					year from the date signed below.	
Birthdate			Sian	ature of Pat	tient, Parent, Guardian or Personal Re	presentative
SS#			3			
Spouse's Employer		ables A ST	Please p	rint name o	f Patient, Parent, Guardian or Persona	I Representative
						diagnosist
Whom may we thank for referring	ng you?	HARMSHOT KONSTRANTACI 1.1		Date	Relationship	to Patient
Phone Nu	mbers					
Phone ()	W	/ork ()	Ext		Alt. Phone ()	Pharmacy Marra
Spouse's Work ()		Best tin	ne and pla	ace to read	ch you	- 1 across 9
IN CASE OF EMERGENCY CO	ONTACT (Specify s	omeone who does not live in you				
	OTTAOT (Opcomy o			na.)		
Name		Relation				
Phone ()		Work P	hone ()		
Dental Hi	istory					
Reason for today's visit		Chew on one side of mouth	Yes	□No	Mouth breathing	☐ Yes ☐ No
APPA TRI SERBELLE ALE MINISTERIO DE LA TRIBATA DE LA TRIBA		Cigarette, pipe, or cigar smoking		□ No	Mouth pain, brushing	☐ Yes ☐ No
Former Dentist	to provide the tribution of Agent the policy to the policy of the tribution of the tributio	Clicking or popping jaw		□ No	Orthodontic treatment	Yes No
City/State Date of last dental visit	9180	Dry mouth Fingernail biting		☐ No	Pain around ear Periodontal treatment	☐ Yes ☐ No
Date of last dental X-rays		Food collection between the teetl		□ No	Sensitivity to cold	Yes No
Place a mark on "yes" or "no" to		Foreign objects		□ No	Sensitivity to heat	Yes No
have had any of the following:		Grinding teeth		☐ No	Sensitivity to sweets	☐ Yes ☐ No
Bad breath	☐ Yes ☐ No	Gums swollen or tender	Yes	☐ No	Sensitivity when biting	☐ Yes ☐ No
Bleeding gums	Yes No	Jaw pain or tiredness		□ No	Sores or growths in your mouth	☐ Yes ☐ No
Blisters on lips or mouth	☐ Yes ☐ No	Lip or cheek biting		□ No	How often do you floss?	SWINNESS SWINNESS
Burning sensation on tongue	☐ Yes ☐ No	Loose teeth or broken fillings	Yes	☐ No	How often do you brush?	and the second

Physician's Name			Date of last	visit			
Have you ever used a bisphosp	phonate medication	? Common brand names a			I Boniva. □ Yes	□No	
Have you ever taken any of the							amac
phentermine), Pondimin (fenflui	ramine) and Redux	(dexfenfluramine).	□ No	mbinations o	Horimin, Adipex, Fas	suii (biand i	lames
Place a mark on "yes" or "no" to AIDS/HIV	indicate if you have	re had any of the following: Epilepsy	☐ Yes ☐ No	Respirat	ory Disease	Yes	□ No
Anemia	Yes No	Fainting or dizziness	Yes No			Yes	
Arthritis, Rheumatism	Yes No	Glaucoma	Yes No			☐ Yes	
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No		ss of Breath	☐ Yes	
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No			☐ Yes	
Asthma	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No			Yes	ΠN
Back Problems	☐ Yes ☐ No	Hepatitis Type	☐ Yes ☐ No		Diet	☐Yes	\square N
Bleeding abnormally, with	400	Herpes	☐ Yes ☐ No			Yes	□N
extractions or surgery	Yes No	High Blood Pressure	☐Yes ☐ No		Feet or Ankles	Yes	□ N
Blood Disease	Yes No	Jaundice	☐ Yes ☐ No	Swollen	Neck Glands	Yes	□ N
Cancer	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No		Problems	☐ Yes	□ N
Chemical Dependency	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	,		☐ Yes	□ N
Chemotherapy	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No			☐ Yes	□ N
Circulatory Problems	Yes No	Low Blood Pressure	☐ Yes ☐ No	Tumor or	growth on head		
Congenital Heart Lesions	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	or neck		☐ Yes	\square N
Cortisone Treatments	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Ulcer		☐ Yes	
Cough, persistent or bloody	☐ Yes ☐ No	Pacemaker	Yes No	Venerea	Disease	☐ Yes	
Diabetes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Weight L	oss, unexplained	Yes	
Emphysema	☐ Yes ☐ No	Radiation Treatment	- ☐ Yes ☐ No				
Do you wear contact lenses?	☐ Yes ☐ No						
Women:							
Are you pregnant?	☐ Yes ☐ No	Due date		Are you	nursing? Yes	No	
Taking birth control pills?	☐ Yes ☐ No						
Medication Medication	ons		Alle	ergies			
List any medications you are cu	urrently taking and	the correlating	☐ Aspirin		☐ Local Anestheti	С	
diagnosis:			☐ Barbiturates (Slee	eping pills)	Penicillin		
	Section 1 to 1985 At 1 to 1975 At 1		☐ Codeine	opg pe,	☐ Sulfa		
			lodine		Other		-
Pharmacy Name	f Phonos (A 199	Latex			-	
Phone ()	nov.	doger of eogle been send is					
Friorie ()							
Updates (To be filled in at fut	ure appointments)					
Has there been any change in	your health since y	our last dental appointment	? Yes No				
For what conditions?							
Are you taking any new medica	ations?	If so, what?			198	for today's t	nozise
Patient's Signature		aki say i gada	प्रकाशिक होते हैं जिस्से अप	Date			
			Total Sections of Contract,	·		The state of the s	100111
Doctor's Signature				Date			
Has there been any change in	vour health since w	our last dental appointment	? Tyes TNo				
ovi [] _est[]	Sent of physics.	our last dental appointment	? Yes No				
Has there been any change in the second seco	Seed of physicals	SM TO ANY	Abalias needs	a saya	rays / "or "no" to indicate colorated	lest derital mark on "a	10 Sta 8 SOB 64 SOB

Date_Date_

Patient's Signature _

Doctor's Signature