## Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

			Patient #
D-4'	AND REPORT OF THE PARTY OF THE		SS#/SIN
Patient Inform	ation (CONFI)	DENTIAL)	Date
Name	DALISACENI ENGLE STANDANDO	Birthdate	Home Phone
Address		City	State/ Zip/ ProvP.C
LITIUII		CEIL FROME	1865
Check Appropriate Box: ☐ Minor	☐ Single ☐ Married [	☐ Divorced ☐ Widowed	Separated Fall Part
If Student, Name of School/College		City	State/ Full Part Prov. Time Time
Patient or Parent/Guardian's Emplo	oyer	1 1 14 To ren with girk K	Work Phone
Business Address		City	State/ Zip/ Prov. P. C.
Spouse or Parent/Guardian's Name	2	Employer	Work Phone
Whom may we thank for referring	you?	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
Person to contact in case of emerge	ency	LECTROTICS FOR ID	Phone
Responsible Pa	irty	in the second process of the	
Name of Person Responsible for the		e yes	Relationship to Patient
Address	market)		Home Phone
Email			Cell Phone
Driver's License#			
Employer	The second linears	Work Phone	SS#/SIN
Cash Personal Check Insurance Info	rmation <sup></sup>	Discover AMEX	wish to discuss the office's payment policy.  Relationship to Patient
Name of Insured			
Birthdate			Date Employed
Name of EmployerAddress of Employer	Market Ma	Union or Local#	Work Phone Zip/
Insurance Company		-	Ctatal 7im/
Ins. Co. Address		The second secon	
How much is your deductible?	CHECK AS COMPANIES .		
DO YOU HAVE ANY ADDITIO	NAL INSURANCE?	Yes No IF YES, C	OMPLETE THE FOLLOWING:
Name of Insured		yattaa	Relationship to Patient
Birthdate	SS#/SIN	76pH2/22	Date Employed
Name of Employer		Union or Local#	Work Phone
Address of Employer		City	State/ Zip/ Prov. P. C.
Insurance Company		Group#	Policy/ID#
Ins. Co. Address	Assembly the second sec	City	Statě/ Zip/ Prov. P. C.
How much is your deductible?	How much	n have you used?	Max. annual benefit

ignature of patient (or parent/guardian if minor)  Date		Office Phone _		N-10-16		Date of Last Exam		
Hone you ever been hospitalized for any suggical operation are serious (these within the last 5 years?   10. Are you taked on revenue these self-within the last 5 years?   10. Are you taking on revenue these within the last 5 years?   10. Are you taking on revenue these self-within the last 5 years?   10. Are you taking on revenue the following?   10. Are you taking on revenue the following?   10. Are you taking on revenue the following?   10. Are you taking on revenue to the following?   10. Are you taking on the following?   10. Are you take you may be pregnant?   10. Are you take you take you may be pregnant?   10. Are you take you take you take you take you may be pregnant?   10. Are you take you t	NEW PROPERTY.			0 1		dura and and laware?		No
Lecal Ameribetics (e.g. Nonocam)  Local Ameribetics (e.g. Nonocam)  Local Ameribetics (e.g. Nonocam)  Local Ameribetics  Sulfa Drugs  Barbiturates  Barbiturates  Sulfa Drugs  Barbiturates  Sulfa Drugs  Barbiturates  Sulfa Drugs  Barbiturates  Sulfa Drugs  Barbiturates  Bar			П	10 Ares	ou weur	to as have you had any reactions to the following?		
## Special and a	Have you ever been hospitalized for any							
Salga Drugs.  Are you taking any medication(s)  michaling non-prescription medicine?  If yes, what medication(s) are you taking?  Hone you ever taken Forners, growth, Actined or any cancer medications containing hisphosphonates?  Do you take tobes of the Forners, Browth, Actined or any cancer medications containing hisphosphonates?  Do you take tobes of the Pressure.  Hence you ever taken Forners, Browth, Actined or any cancer medications containing hisphosphonates?  Do you take tobes of the Pressure.  Hence you ever taken Forners, Browth, Actined or any cancer medications containing hisphosphonates?  Do you take tobes of the Pressure.  Hence you ever taken Forners, Browth, Actined or any cancer medications containing hisphosphonates?  Do you take use controlled substances?  Do you take use controlled substances?  Do you take or have you had any of the following?  Yes No  Heart Dissesse  Heart Marmu  Stockers  Octes Pains.  Heart Marmu  Storbe  Swollen Ankles.  Heart Marmu  Storbe  Swollen Ankles.  Angina  Hus Fever/Allergies.  Frequently Tried  Tuberculosis.  Asthura.  Anemaia  Anemaia  Radiation Therapy  Galtaucoma  Galtaucoma  Galtaucoma  Anemaia  Cardenes  Anthura.  Anemaia  Radiation Therapy  Heart Trouble.  Scouldly Tunsmitted Disease  Respiratory Problems  Heart Trouble.  Scouldly Tunsmitted Disease  Respiratory Problems  Mittal Valve Prolapse.  Other  Part your teeth sensitive to hot or cold liquids/goods?  Do you large pain to any of your teeth?  Do you get pain to any of your teeth?  Do you get pain to any of your teeth?  Do you had any head, neck or iaw injuries?  Heav you ever head any difficult extractions in the past?  Heav you cere selection and Release  refly that I have read and understand the above information to the best of my knowledge. The above questions have been accurately anywered.  Market your ever head and yidifficult extractions in the past?  Heav you were well and my difficult extractions in the past?  Heav you were reduced and prolling for the following problems in your jaw?  Heave		5 years?	l Un	Penic	illin or a	any other Antibiotics	· 🗖	
Are you taking any medication(s)  mediuding non-prescription mediane?    Jess, what mediation(s) are you taking?   April   Apr	If yes, please explain							
Are you taking any medication(s)  If yes, what medication(s) are you taking?  How you ever taken Feer-Pheny Redux?  How you ever taken Feer-Pheny Redux?  How you ever taken Feer-Pheny Redux?  Do you use controlled substances?  Do you have or have you had any of the following?  Do you have or have you had any of the following?  Do you have or have you had any of the following?  Do you have or have you had any of the following?  Do you have or have you had any of the following?  Do you have or have you had any of the following?  Do you have or have you had any of the following?  Do you have or have you had any of the following?  Do you have or have you had any of the following?  Do you have or have you had any of the following?  Do you have or have you had any of the following?  Do you have or have you had any of the following?  Do you have or have you had any of the following?  Do you have or have you had any of the following?  Do you have or have you had any of the following?  Do you have or have you had any of the following?  Do you have or have you had any of the following?  Do you have you had any of the following had you have you had any of the following had you have you had you you have you you y	Allegan of Francisco							
Speriment   Aspirim   As		9.48						
Spex, what medication(s) are you tolong   Aspirin.				Iodin	e			
Hene you ever taken Fen-Phen/Reduct?    Laties Rubber   Chellery   Cheller   Chellery	If yes, what medication(s) are you taking?			Aspir	in		. 🔲	
Have you ever taken Fosamaes, Bonisa, Actoned or any cancer medications containing hisphosphorates?  Do you use touthout a substances?  Do you use controlled substances?  Do you use controlled substances?  Do you had any of the following?  Do you have or have you had any of the following?  Do you have or have you had any of the following?  Do you have or have you had any of the following?  Do you have or have you had any of the following?  Do you fall for the following?  Do you taking oral contraceptives?  So No Yes N								
medications containing bisphosphomates?  Do you use tobacco?  Do you have or have you had any of the following?  Yes No  Heart Disease.  Gardiac Pacemaker.  Heart Disease.  Gardiac Pacemaker.  Heart Attach.  Michaematic Fever.  Swollen Anklies.  Santing / Selzyues.  Angina.  Angina.  Stroke.  Service No Chest Pains.  Stroke.  Gardiac Pacemaker.  Hay Fever / Allerges.  Straining / Selzyues.  Asthma.  Anemia.  Anemia.  Anemia.  Anthritis.  Diabetes.  Joint Replacement or Implant.  Kidney Disease.  High Rood Pressure.  Emphysema.  Galactom.  Arthritis.  Diabetes.  Hay Fever / Allerges.  Theoretalesis.  Galactom.  Arthritis.  Diabetes.  Hay Fever / Allerges.  Theoretalesis.  Joint Replacement or Implant.  Hay Fever / Allerges.  Theoretalesis.  Arthritis.  Diabetes.  Hay Fever / Allerges.  Theoretalesis.  Asthma.  Radiation Therap.  Garcer.  Garcer.  Heart Murmuru.  Stroke.  Garcer.  Hay Fever / Allerges.  Asthma.  Radiation Therap.  Bradiation Therap.  Garcer.  Hay Fever / Allerges.  Asthma.  Radiation Therap.  Bradiation	Have you ever taken Fen-Phen/Redux?						. [	
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Do you use tobacco? Do you use controlled substances? Do you have or have you had any of the following? Yes No Heart Disease. Heart Attack. Heart Marke. Heart Marmur Mowled Pressure. Heart Marmur Marmur Mowled Pressure. Heart More More More More More More More More	medications containing bisphosphonates?			11. Doy	ou have a	persistent cough or throat clearing not		
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Do you have or have you had any of the following?  Yes No High Blood Pressure. Heart Disease. Chest Pains. Cardiac Pacemaker Heart Attack Rheamatic Fever Worlden Ankles. Rheart Attack Rheamatic Fever Heart Murmur. Stroke. Rheart Attack Rheamatic Fever Worlden Ankles. Rheamatic Fever Heart Murmur. Stroke. Rheart Murmur. Rheart Murmur. Stroke. Rheart Murmur. Rheart Murmur. Stroke. Rheart Murmur. Rheart Murmur. Rheart Murmur. Rheart Murmur. Stroke. Rheart Murmur. Rheart Murmur. Rheart Murmur. Rheart Murmur. Stroke. Rheart Murmur. Rh	1 Chickey Coleman							
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Heart Disease   Chest Pains   Cardiac Pacemaker   Cardiac Pacemake				c) Ar	e you tal	ring oral contraceptives?		NI.
Heart Attack.   Cardiac Pacemaker   Easily Winded   Recommediate		II D'						INC
Skewlen Ankles.  Angina   Hay Fever / Allergies   Tuberculosis   Hay Fever / Allergies   Tuberculosis   Angina   Hay Fever / Allergies   Tuberculosis   Tuberculosis   Angina   Hay Fever / Allergies   Tuberculosis   Angina   Hay Fever / Allergies   Tuberculosis   Angina   Hay Fever / Allergies   Tuberculosis   Angina   Tuberculosis   Tuberculosis   Angina   Tuberculosis   Tube	Heart Attach							
Swollen Ankles					H			
Frequently Tired.  Anthoma.  Anthoma.  Anthoma.  Anthoma.  Briphysema.  Emphysema.  Emphys								H
Asthma		Frequently Tired						
Leukemia   Arthritis   Recent Weight Loss   Cancer   Repilegey / Convulsions   Cancer   Recent Weight Loss   Cancer   Replates / Cancer   Registratory Problems   Cancer   Repatitis / Replatement or Implant   Liver Disease   Cancer   Repatitis / Replates / Repatitis / Replates / Repatitis / Replates / Repatitis / Repa								
Cancer   C								
Cation Dental History  Patient Dental History  ame of Previous Dentist and Location  Do you gums bleed while brushing or flossing?  Are your teeth sensitive to hot or cold liquids/foods?  Do you gums bleed while brushing or flossing?  Are your teeth sensitive to sweet or sour liquids/foods?  Do you feel pain to any of your teeth?  Do you feel pain to any of your teeth?  Have you ever had any heful extractions in the past?  Have you ever had any prolonged bleeding following problems in your jaw?  Clicking.  Pain (foint, ear, side of face)  Difficulty in opening or closing  Difficulty in chewing  The provious Dental and Release  Are that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered mearstand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the grows and the accurately answered mearstand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the grows and the records of any treatment or examination rendered to mor or my child during the period of such Dental care to third party payors down health of paying the accurately answered mearstand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the grows and the records of any treatment or examination rendered to mor or my child during the period of such Dental care to third party payors down health of paying the period of such Dental care to third party payors down health of paying the period of such Dental care to third party payors down health of paying the period of such Dental care to third party payors down health of paying the	Epilepsy / Convulsions	Cancer						
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Thyroid Problem   Stomach Troubles / Ulcers   Other   Other    Patient Dental History  ame of Previous Dentist and Location   Yes No   Yes					H			
Patient Dental History  ame of Previous Dentist and Location  Do your gums bleed while brushing or flossing?  Are your teeth sensitive to not or cold liquids/foods?  Do you feel pain to any of your teeth?  Do you have any sores or lumps in or near your mouth?  Have you had any head, neck or jaw injuries?  Have you ever experienced any of the following problems in your jaw?  Clicking.  Pain (joint, ear, side of face).  Difficulty in opening or closing.  Authorization and Release  ertify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the growth of any retardent or rexamination rendered to me or my child during the period of such period such characterists. I authorize and request my insurance company to pay less than the actual bill for services, I agree to be responsible expressed on the pastricus of patient (or parent/guardian if minor)  Date  Doctor's Comments		Stamach Transmi	ittea Dise	ase	H	Mitral Valve Prolanse		
Patient Dental History  ame of Previous Dentist and Location	Acid Reflux				H			
Ves No Do your gums bleed while brushing or flossing?		ry						
Do your gums bleed while brushing or flossing?	ame of Previous Dentist and Location					Date of Last Exam		
Are your teeth sensitive to hot or cold liquids/foods?   9. Do you clench or grind your teeth?   10. Do you lite your lips or cheeks frequently?   11. Have you leel pain to any of your teeth?   11. Have you ever had any difficult extractions in the past?   12. Have you ever had any prolonged bleeding flowing problems in your jaw?   13. Have you had any prolonged bleeding flowing extractions?   14. Do you wear dentures or partials?   15. Have you wear dentures or partials?   16. Do you like your smile?   17. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?   16. Do you like your smile?   16. Do you like your smile?   17. Have you you were received oral hygiene instructions regarding that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the agnosts and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors herewise payable to me. I understand that my dental insurance company to pay directly to the dentist or dental group insurance benefits rewise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible payment of all services rendered on my behalf or my dependents.		and the same of th	es No		199	Kelen minute		No
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Do you feel pain to any of your teeth?			_					
Do you have any sores or lumps in or near your mouth?       in the past?			1 1	10. Do y	ou bite y	our lips or cheeks frequently?	🗀	
Have you had any head, neck or jaw injuries?	Do you feel pain to any of your teeth?	L						
Have you ever experienced any of the following problems in your jaw?  Clicking	Do you have any sores or lumps in or near your	mouth?					🔲	
Problems in your jaw?  Clicking		L		12. Have	you eve	r had any prolonged bleeding		_
Clicking								
Pain (joint, ear, side of face)								
Difficulty in opening or closing	Clicking	L					Ц	
Difficulty in chewing	Pain (joint, ear, side of face)		4 4	If yes	, date of	placement		
Authorization and Release  sertify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered, understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the agnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors dofor health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits herwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible repayment of all services rendered on my behalf or my dependents.  A lignature of patient (or parent/guardian if minor)  Date  Doctor's Comments  Doctor's Comments				15. Have	you eve	r received oral hygiene instructions		
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