## 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 #
Dati and Informati		SS#/SIN
Patient Information	ON (CONFIDENTIAL)	Date
Name	Birthdate	Home Phone Zip/
Address	City	State/ Zip/ Prov. P.C.
Email	Cell Phone	
** *	ngle □ Married □ Divorced □ Widowed □  City	State/ Full Part
		Work Phone
	City	State/ 7in/
	Employer	
Responsible Party		
Name of Person Responsible for this Acco		Relationship to Patient
Address		Home Phone
Email		Cell Phone
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	Birthdate Financial Instit	ution
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Are you under medical treatment now? How you ever been hospitalized for any surgical operation or serious illuses within the lost 5 years?  If we you wearing contact lenses?  If we you wear hospitalized for any surgical operation or serious illuses within the lost 5 years?  If yes, please explain  Are you tabling any medication (s)  mediuling non-prescription medicine?  If yes, what medication (s) are you taking?  Have you ever taken Formea, Bomise, Actined or any cancer  medications containing hisphaphomates?  Have you ever taken Formea, Bomise, Actined or any cancer  medications containing hisphaphomates?  Have you tever taken Formea, Bomise, Actined or any cancer  medications containing hisphaphomates?  Have you tever taken Formea, Bomise, Actined or any cancer  medications containing hisphaphomates?  Have you tever taken Formea, Bomise, Actined or any cancer  medications containing hisphaphomates?  Have you tever taken formea, Bomise, Actined or any cancer  medications containing hisphaphomates?  Have you tever taken formea, Bomise, Actined or any cancer  medications containing hisphaphomates?  If we you taken you had any of the following?  Do you take others you had any of the following?  Do you take other you had any of the following?  If we you taking and contracquitives?  If we you taking	Physician	Office Phon	1e		Date of Last Exam		
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Hone you ever been hospitalized for any surgical operation or serious illness within the last 5 years?							
Local Anesthetics (e.g. Novocain)   Jyes, please explain   Present   Prese							
Penicillin or any other Antibiotics   Stift Drugs   Penicillin or any other Antibiotics   Penicillin or any other Antibiotics   Penicillin or any other Antibiotics   Penicillin Drugs   Penicillin or any other Antibiotics   Penicillin Or any other Antibiotics   Penicillin Or any other Penicillin Or any other Antibiotics   Penicillin Or any other Antibiotics   Penicillin Or any other Penicillin Or any other Antibiotics   Penicillin Or any other penicillin Or any oth		last 5 years?					
Sulfa Drugs.		. ust 5 years?		-			
Any was abling any medications (S) including non-perception medicated.  If yes, what medication(s) are you taking?  How you ever taken Fen-Phet/Reduc?  How you ever taken Foomance, Boniva, Actorel or any cancer medications containing bephosphomates?  In the sea? How containing bephosphomates?  Do you use controlled substances?  Do you have or home you had any of the following?  Yes No  Any you runsing?  O Are you tacking ord contractptives?  O Are you tacking ord co	ıj yes, piease expiain					F	
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Jiyes, what medication(s) are you taking?   Aspirin. As	including non-prescription medicine?					H	
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In the last 24-hours.  Do you use controlled substances?  Do you use controlled substances?  Do you have or have you had any of the following?  Ves No  High Blood Pressure  Teart Attack  Heart Disease  Heart Murmur  Heart Murm	. Have you taken Viagra, Revati, Cialis or Levi	ra					
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Do you use controlled substances?  Do you have or have you had any of the following?  Yes No  Heart Disease Sector Attack Cardiac Paccenaker Seven No  Seven	. Do you use tobacco?					П	
Do you have or have you had any of the following?  Yes No  Yes No  Heart Disease  Gardiac Paccenaker  Heart Mumur  Stroke  Swollen Ankles  Angina  Hay Fever / Allergies  Frequently Tired  Taberculosis  Stroke  Angina  Hay Fever / Allergies  Frequently Tired  Taberculosis  Stroke  Taberculosis  Stroke  Swollen Ankles  Angina  Hay Fever / Allergies  Taberculosis  Taberculosis  Stroke  Taberculosis  Tabercul	Do you use controlled substances?				h) An are you pregnant or thank you may be pregnant:	H	
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Heart Disease   Chest Pains   Chest Pains   Chest Pains   Cardiac Pacemaker   Easily Winded   Cardiac Pacemaker   Easily Winded Male Pacemaker   Easily Wind							
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Joint Replacement or Implant   Heart Trouble   Heart Trouble   Heart Its / Jaundice   Respiratory Problems   Gatient Dental History   Sexually Transmitted Disease   Mitral Valve Prolapse   Other   Date of Last Exam   Do your gums bleed while brushing or flossing?   Stomach Troubles / Ulcers   Do you was frequent headaches?   Stomach Brown teeth sensitive to hot or cold liquids/foods?   9. Do you clench or grind your teeth?   Do you feel pain to any of your teeth?   Do you feel pain to any of your teeth?   Do you feel pain to any of your teeth?   Do you feel pain to any of your teeth?   Do you have any sores or lumps in or near your mouth?   11. Have you ever had any difficult extractions   In the past?   Do you have get experienced any of the following   In Have you ever had any prolonged bleeding   Following extractions?   If yes, date of placement   Do you feel pain to any of your jaw?   In Have you ever had any prolonged bleeding   Following extractions?   If yes, date of placement   Do you feel pain to prove the providing in or closing   If yes, date of placement   Do you was deficilly in chewing   If yes, date of placement   Do you feel pain to providing incorrect information to the best of my knowledge. The above questions have been accurately answere anderstand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the providing incorrect information can be dangerous to my health. I authorize the dentist or dental group insurance benefits envirence of any vertile during the period of such Dental Care to third party pay difference to meet an understand t	Leukemia	Arthritis			Liver Disease		
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Are your teeth sensitive to sweet or sour liquids/foods?	Are your teeth sensitive to hot or cold liquid	3/foods?			9. Do you clench or grind your teeth?	Ш	
Do you feel pain to any of your teeth?	Are your teeth sensitive to sweet or sour lian	ids/foods?					1
Do you have any sores or lumps in or near your mouth?							
Have you had any head, neck or jaw injuries?			H	H			1
Have you ever experienced any of the following  problems in your jaw?  Clicking				H			-
problems in your jaw?  Clicking							
problems in your jaw?  Clicking		3			following extractions?		
Clicking	problems in your jaw?				13. Have you had any orthodontic treatment?		
Pain (joint, ear, side of face)							
Difficulty in opening or closing	Pain (joint ear side of face)						
Difficulty in chewing	Diff with in a 1		H		15 H		
ertify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answere nderstand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the general party of any treatment or examination rendered to me or my child during the period of such Denial care to third party payed and the records of any treatment or examination rendered to me or my child during the period of such Denial care to third party payed or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits nerwise 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 dependants.  **Grature of patient** (or parent/guardian if minor)**  **Date**  **Date**					15. Have you ever received oral hygiene instructions		
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gnature of patient (or parent/guardian if minor)  Date	Authorization and	Release		best of my his of me of the original pany			-
gnature of patient (or parent/guardian if minor)  Date	d/or health practitioners. I authorize and	request my insuranc		er may	p pay less than the actual bill for services. I agree to be respon	sible	
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Doctor's Comments	nd/or health practitioners. I authorize and herwise payable to me. I understand that n ir payment of all services rendered on my b	request my insuranc iy dental insurance chalf or my dependa	carrie ints.				
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	gnature of patient (or parent/guardian i	f minor)			Date		