

Last Name: \square MR. \square MRS . \square MS. □ DR. I prefer to be called: □Male Gender: ☐ Female Marital status: (Please select one) □ Single ☐ Married ☐ Divorced □Widowed □ Separated Birthdate: SS# Age: City: Zip: Home Address: State: E-Mail Address: Home #: () Cell# () Work # (Ext. **Employer:** Employer's Address: How long there? Occupation: Where and when are the best times to reach you? Whom may we thank for referring you? Other family members seen by us: Previous / Present Dentist: Last dental visit date: **SPOUSE INFORMATION** Last Name: First: M.I. \square MR. \square MRS . \square MS. □ DR. Birthdate: Age: SS# Employer: Work# (Ext. Person Responsible for Account: Relation: Billing Address: City: State: Zip: SS# Employer: **INSURANCE INFORMATION** PRIMARY COVERAGE Dental Coverage: \square YES \square NO Insurance Company: Ph #: (City: Zip Insurance Address: State Group # (Plan, Local or Policy #): Insured's ID# Insured's Employer: Insured's Name: Relation: Insured's Birthday: **SECONDARY COVERAGE** SECONDARY COVERAGE Dental Coverage: \square YES \square NO Ph #: (Insurance Company: Insurance Address: City: State Zip Group # (Plan, Local or Policy #): Insured's ID# Insured's Employer: Insured's Name: Relation: Insured's Birthday: **EMERGENCY INFORMATION**

His / Her name:

Home #: (

In the event of an emergency, is there someone who lives close to you that we should contact?

Cell# (

Ext.

Relation:

Work# (

Although derital personnel primarily treat the area in and accountly your mouth is a part of your entitle body. Health problems that you may be taken power and that you may be taken power and that you may be taken power and that you may have, or medications that you may have, or medications that you make a personal physician? YES NO Bate of lists visit: Physician YES NO Physician YES NO Physician YES NO Physician Physician YES NO Physician YES YES NO Physician YES		MEDICAL HISTORY												
Physician's Name: Are you under a physician's care nov? Are you taking any medications, pills or drup;? Have you ever had a serious head or neck injuny? YES NO If yes, please explain: Have you ever had a serious head or neck injuny? YES NO If yes, please explain: Hore you taken Fosamax, or any other bisphosphorate YES NO If yes, please explain: Hore you taken Fosamax, or any other bisphosphorate YES NO If yes, please explain: YES NO If yes, please explain: Do you taken Anae you taken Perfer or Redux? YES NO If yes, please explain: Do you use controlled substances? YES NO If yes, please explain: Do you use controlled substances? YES NO If yes, please explain: YES NO If yes, please explain: Do you use controlled substances? YES NO If yes, please explain: YES NO If yes, please explain: YES NO If yes, please explain: Do you use controlled substances? YES NO If yes, please explain: YES NO If y														
Are you usking any medications, pills or drugs?	Do you have a personal physicia	have a personal physician? □YES □NO				Date of last visit:								
Ave you taking any medications, pills or drugs? CYES NO If yes, please explain:	Physician's Name:									Ph	#: ()	-		
Have you see'n bad a serious head or neck injury?	Are you under a physician's care now?						If yes, please	explain:						
Have you taken Fosamax, or any other bisphosphonate	Are you taking any medications, pills or drugs?							If yes, please explain:						
Have you taken Fosamax, or any other bisphosphonate	Have you ever been hospitalized or had a major operation? ☐ YES ☐ NO						If yes, please explain:							
Do you take, or have you taken Phen Fen or Redux?	Have you ever had a serious head or neck injury? □YES □NO							If yes, please explain:						
Are you make or use tobacce?	Have you taken Fosamax, or any other bisphosphonate □YES □NO							If yes, please explain:						
Do you smoke or use tobacco?	Do you take, or have you taken Phen-Fen or Redux?							If yes, please explain:						
Do you use controlled substances? YES NO If yes, please explain: YES NO YES YE	Are you on a special diet? □YES □NO							If yes, please explain:						
Are you pregnant or trying to get pregnant? YES	Do you smoke or use tobacco? □YES □NO							If yes, please explain:						
Are you taking oral contraceptives? YES NO If yes, please explain: YES NO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING? Aspirin Penicillin Codeine Local Anesthetics Metal Latex Acrylic SULFA DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?: AlDS HIV Positive YES NO Panin the Jaw Joints YES NO Alzheimers YES NO Panin the Jaw Joints YES NO Alzheimers YES NO Panin the Jaw Joints YES NO Anaphylaxis YES NO Paninting Spells / Dizziness YES NO Postpathatic Care YES NO Prequent Couries YES NO Prequent Headaches YES NO Prequ	Do you use controlled substances?							If yes, please explain:						
Are you nursing	Are you pregnant or trying to g	□NO	If yes, please explain:											
AREYOU ALLERGIC TO ANY OF THE FOLLOWING? Aspirin Penicillin Codeine Local Anesthetics Metal Latex Acrylic SULFA	Are you taking oral contracept	□NO	If yes, please explain:											
DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?: AIDS HIV Positive	Are you nursing	□YES	□NO	If yes, please	explain:									
AIDS HIV Positive YES NO Excessive Thirst YES NO Pain in the Jaw Joints YES NO Alzheimers YES NO Fainting Spells / Dizziness YES NO Prathyroid Disease YES NO Anaphylaxis YES NO Frequent Cough YES NO Psychiatric Care YES NO Anaphylaxis YES NO Frequent Cough YES NO Radiation Treatments YES NO Angina YES NO Frequent Headaches YES NO Radiation Treatments YES NO Arthritis/Gout YES NO Genital Herpes YES NO Recent Weight Loss YES NO Arthritis/Gout YES NO Genital Herpes YES NO Recent Weight Loss YES NO Arthritis/Gout YES NO Hay Fever YES NO Heart Attack/Failure YES NO Heart Attack/Failure YES NO Renal Dialysis YES NO Arthritis/Gout YES NO Hart Attack/Failure YES NO Renal Dialysis YES NO Renal Dialysis	ARE YOU ALLERGIC TO ANY	OF THE FOL	LOWING?	□Aspi	irin 🗆 P	enicillin	☐ Codeine	☐ Local Anes	thetics	□Metal	□Latex	□Acrylic	SULFA	
AIDS HIV Positive YES NO Excessive Thirst YES NO Pain in the Jaw Joints YES NO Alzheimers YES NO Fainting Spells / Dizziness YES NO Prathyroid Disease YES NO Anaphylaxis YES NO Frequent Cough YES NO Psychiatric Care YES NO Anaphylaxis YES NO Frequent Cough YES NO Radiation Treatments YES NO Angina YES NO Frequent Headaches YES NO Radiation Treatments YES NO Arthritis/Gout YES NO Genital Herpes YES NO Recent Weight Loss YES NO Arthritis/Gout YES NO Genital Herpes YES NO Recent Weight Loss YES NO Arthritis/Gout YES NO Hay Fever YES NO Heart Attack/Failure YES NO Heart Attack/Failure YES NO Renal Dialysis YES NO Arthritis/Gout YES NO Hart Attack/Failure YES NO Renal Dialysis YES NO Renal Dialysis		DO Y	OU HAVI	E, OR	HAVE	YOU H	AD, ANY	OF THE I	FOLLO	WING	i?:			
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Anemia		□YES		Faintin	ng Spells ,	/ Dizziness	□YES	□NO	Parathy	roid Dise		\square YES		
Angina														
Artificial Heart Valve														
Artificial Heart Valve											OSS			
Arthma				•							_			
Asthma														
Blood Disease														
Blood Tranfusion														
Breathing Problem									3					
Bruse Easily														
Chemotherapy YES NO Hepatitis B or C YES NO Stroke YES NO Chest Pains YES NO Herpes YES NO Herpes YES NO Swelling of Limbs YES NO Cold Sores/Fever Blisters YES NO High Blood Pressure YES NO Thyroid Disease YES NO Congenital Heart Disorder YES NO Hives or Rash YES NO Tonsilitis YES NO Convulsion YES NO Hypoglycemia YES NO Tuberculosis YES NO Tuberculosis YES NO Ortisone Medication YES NO Irregular Heartbeat YES NO Tumors or Growths YES NO Diabetes YES NO No No No No No No No		□YES	□NO				□YES	□NO				\square YES	□NO	
Chest Pains	Cancer	\square YES	□NO				□YES	□NO	•			\square YES	□NO	
Cold Sores/Fever Blisters	Chemotherapy	\square YES	□NO					□NO				\square YES	□NO	
Congenital Heart Disorder YES NO		□ YES	□NO						Swelling of Limbs				□NO	
Convulsion YES NO Hypoglycemia YES NO Tuberculosis YES NO Cortisone Medication YES NO Irregular Heartbeat YES NO Tumors or Growths YES NO Diabetes YES NO Kidney Problems YES NO Ulcers YES NO Ulcers YES NO NO Venereal Disease YES NO Venereal Disease YES NO Easily Winded YES NO Low Blood Pressure YES NO Yellow Jaundice YES NO Emphysema YES NO Low Blood Pressure YES NO Yellow Jaundice YES NO Excessive Bleeding YES NO Mitral Valve Prolapse YES NO Excessive Bleeding YES NO Mitral Valve Prolapse YES NO Yellow Jaundice														
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Diabetes YES NO Kidney Problems YES NO Ulcers YES NO Drug Addiction YES NO Leukemia YES NO Venereal Disease YES NO Easily Winded YES NO Liver Disease YES NO Liver Disease YES NO Emphysema YES NO Low Blood Pressure YES NO Epilepsy or Seizures YES NO Lung Disease YES NO Lung Disease YES NO Excessive Bleeding YES NO Mitral Valve Prolapse YES NO Mitral Valve Prolapse YES NO Have you ever had any serious illness not listed above? YES NO If yes, please explain: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes to medical status. If this office accepts insurance, I understand that I am responsible for payment of services rendered and also repsonsible for paying any co-payment and deductible that my insurance does not cover. Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA. I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.														
Drug Addiction YES NO Leukemia YES NO Venereal Disease YES NO Fasily Winded YES NO Liver Disease YES NO Low Blood Pressure YES NO Emphysema YES NO Low Blood Pressure YES NO Excessive Bleeding YES NO Lung Disease YES NO Mitral Valve Prolapse YES NO NO Mitral Valve Prolapse YES NO NO Mitral Valve Prolapse YES NO Mitral Valve Prolapse YES NO Mitral Valve Prolapse YES NO NO Mitral Valve Prolapse YES NO NO Mitral Valve Prolapse YES NO NO Mitral Valve Prolapse YES														
Easily Winded YES NO Liver Disease YES NO Yellow Jaundice YES NO Emphysema YES NO Low Blood Pressure YES NO Lung Disease YES NO Epilepsy or Seizures YES NO Nitral Valve Prolapse YES NO Mitral Valve Prolapse YES NO No Nitral Valve Prolapse YES NO Nitral Valve Prolapse YES NO No Nitral Valve Prolapse YES NO Nitral Valve Prola														
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Epilepsy or Seizures YES NO No No No No No No No									TCHOW 3	adriaice		_ 1LJ		
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