ANS/HIV+				GENE			ш	
DeNTAL HISTORY 1. Reason for Visit / Main Concern? Check-Up Cleaning Toothache Other	DATE:		HE	ALTH INF	ORMATION (HARI	#	
DeNTAL HISTORY 1. Reason for Visit / Main Concern? Check-Up Cleaning Toothache Other	PATIENT NAME:	LAST		FIR	BI	IRTH DATE:		_ AGE:
2. Are there other conditions of which we should be aware? YES \Rightarrow NO \Rightarrow It yes, please specify: 3. When did you last visit a dentist? 4. What treatment was performed? 5. Was the treatment completed? 6. When were dental x-rays taken? 9. Have you was a cleaning of YES \Rightarrow NO \	DENTAL HISTORY							
2. Are there other conditions of which we should be aware? YES□ NO□ If yes, please specify: 3. When did you last visit a dentist? 4. What treatment was performed? 5. Was the treatment completed? 7. Did you have a cleaning? YES□ NO□ 8. Have you had gum (periodontal) treatment? YES□ NO□ If yes, please specify: 10. Have you had any problems with past dental treatment? YES□ NO□ If yes, please specify: 11. De you grind your teeth, flicinch your java, or have symptoms near your ears such as clicking, popping, pan or locking open? YES□ NO□ If yes, please specify: 12. Have you had any problems with past dental treatment? YES□ NO□ If yes, please specify: 13. De your gind your teeth, flicinch your java, or have symptoms near your ears such as clicking, popping, pan or locking open? YES□ NO□ If yes, please specify: 14. Have you over been diagnosed or treated for TMD (Temporormandibular Joint Dysfunction) sometimes called TMJ? YES□ NO□ If yes, please specify: 15. Are your feeth sensitive to hot or cold? YES□ NO□ If yes yellow you have bad breath? YES□ NO□ 16. Would you like your teeth white?? YES□ NO□ 17. Are you happy with your smile? YES□ NO□ If yes, please specify: 19. Phone: () 10. Phone: () 10. Phone: () 10. Phone: () 11. Are you under a Doctor's care at this time? YES□ NO□ If yes, please specify: 10. Phone: () 11. Are you under a Doctor's care at this time, including birth control? YES□ NO□ If yes, please specify: 12. Are you allergic to penicillin, codding, local anesthetes, tranquilizers or any other drugs or medicine? 13. Are there any other health problems of which we should be advised? Please specify: 14. (Women) Are you pregnant now? YES□ NO□ If yes, please specify: 15. Are there any other health problems of which we should be advised? Please specify: 16. Do you have, or have you had, any of the following? 17. Please check "YES□ No□ I HePATITIS YES□ No□	1. Reason for Visit /	Main C	oncern? Checl	k-Up 🖬 Clea	ning Toothache	Other		
5. Was the treatment completed?	2. Are there other condi-	tions of v	which we should	be aware?	YES I NO I If yes, plo	ease specify		
1. Did you have a cleaning ? YES □ NO □ 1. Have you had gum (periodontal) treatment? YES □ NO □ 1. Have you had any problems with past dental treatment? YES □ NO □ 1. Yes, please specify: □ 1. Did you grind your teeth, clinch your javes, or have symptoms near your ears such as dicking, popping, pain or locking open? YES □ NO □ 1. Yes, please specify: □ 1. Did you grind your teeth, clinch your javes, or have symptoms near your ears such as dicking, popping, pain or locking open? YES □ NO □ 1. Yes, please specify: □ 1. Did 1. Yes, please specify: □ 1. Did 1. Yes, please specify: □ 1. Did 1. Yes □ 1. Did 1. D								
9. Have you had any prolonged bleeding after an extraction? YES NO If yes, please specify: 11. De you grind your feelth, clinch your jaws, or have symptoms near your ears such as clicking, popping, pain or locking open? YES NO If yes, please specify: 12. Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction) sometimes called TMJ? YES NO If yes, please specify: 13. De your gims bleed easily? YES NO 14. De you feel you have bad breath? YES NO 15. Are your teeth sensitive to hot or cold? YES NO 16. Would you like your teeth whiter? YES NO 17. Are you happy with your smile? YES NO 16. Would you like your teeth whiter? YES NO 17. Are you happy with your smile? YES NO 18 yes, please explain: MEDICAL HISTORY 1. Are you under a Doctor's care at this time? YES NO 18 yes, please specify: Dr. Name: Dr. Phone: () Dr. Pho	5. Was the treatment co	mpleted'	? :s d Nod		6. When were denta			
10. Have you had any problems with past dental treatment? YES □ NO □ If yes, please specify: 11. Do you grind your feeth, clinch your jave, or have symptoms near your ears such as clicking, popping, pain or locking open? YES □ NO □ If yes, please specify: 12. Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction) sometimes called TMJ? YES □ NO □ If yes, please specify: 13. Do your gums bleed easily? YES □ NO □ 16. Would you like your teeth whiter? YES □ NO □ 15. Are you treeth sensitive to hot or cold? YES □ NO □ 16. Would you like your teeth whiter? YES □ NO □ 17. Are you happy with your smile? YES □ NO □ If no, please explain: MEDICAL HISTORY 1. Are you under a Doctor's care at this time? YES □ NO □ If yes, please specify: 2. Are you altergic to penicillin, codeine, local anesthetics, tranquilizers or any other drugs or medicine? 3. Are you altergic to penicillin, codeine, local anesthetics, tranquilizers or any other drugs or medicine? 3. Are you altergic to penicillin, codeine, local anesthetics, tranquilizers or any other drugs or medicine? 4. (Women) Are you pregnant now? YES □ NO □ If yes, how many months? □ Are you nursing? YES □ NO □ If yes, please specify: 4. (Women) Are you pregnant now? YES □ NO □ If yes, how many months? □ Are you nursing? YES □ NO □ No If yes, please specify: 5. Are there any other health problems of which we should be advised? Please specify: 6. Do you have, or have you had, any of the following? Please check "YES" or "NO" □ Doctor Comments ARTHFICIAL HEART VALVE YES □ NO □ □ HEARTITIS YES □ NO □ □ No □ No □ No □ No □ No □ No □								
YES NO If yes, please specify:	10. Have you had any problems with past dental treatment? YES □ NO □ If yes, please specify:							
YES NO If yes, please specify: 14. Do you feel you have bad breath? YES NO 15. Are your teeth sensitive to hot or cold? YES NO 16. Would you like your teeth whiter? YES NO 17. Are you happy with your smile? YES NO 16. Would you like your teeth whiter? YES NO 17. Are you happy with your smile? YES NO If no, please explain:	YES INO If yes,	please	specify:					
13. Do your gums bleed easily? YES	12. Have you ever been of YES □ NO □ If yes,	diagnose please :	d or treated for specify:					
MEDICAL HISTORY No If no, please explain: Dr. Name: Dr. Phone: ()	13. Do your gums bleed easily? YES \(\sigma\) NO \(\sigma\) 14. Do you feel you have bad breath? YES \(\sigma\) NO \(\sigma\)							
MEDICAL HISTORY 1. Are you under a Doctor's care at this time? YES NO If yes, please specify:	15. Are your teeth sensitive 17. Are you happy with yo	e to hot our smile	or cold? YES ⊔ ?YES □ NO □	NO ⊔ ⊒ If no, please ∈	16. Would you like yo explain:	ur teeth white	er? YES⊔	NO 🗖
1. Are you under a Doctor's care at this time? YES NO If yes, please specify: Dr. Phone: ()			202	, p.eaee .				
Dr. Phone: ()		or's care	at this time? YE	S NO If y	es, please specify:	Dr.	Name:	
3. Are you taking any medications at this time, including birth control? YES \(\text{ NO } \) If yes, please specify: 4. (Women) Are you pregnant now? YES \(\text{ NO } \) If yes, how many months? Are you nursing? YES \(\text{ NO } \) S. Are there any other health problems of which we should be advised? Please specify: 5. Are there any other health problems of which we should be advised? Please specify: 6. Do you have, or have you had, any of the following? Please check "YES" or "NO"						Dr. Phone:	()	
5. Are there any other health problems of which we should be advised? Please specify: 6. Do you have, or have you had, any of the following? Please check "YES" or "NO"								
5. Are there any other health problems of which we should be advised? Please specify: 6. Do you have, or have you had, any of the following? Please check "YES" or "NO" Doctor Comments ARTIFICIAL HEART VALVE YES NO HEPATITIS YES NO AND AIDSHINH YES NO	4 (Women) Are you pred	nant no	w2 YES□ NOI	If yes how n	nany months?	Δre vo	u nursina?	YES D NO D
Please check "YES" or "NO"								
ARTIFICIAL HEART VALVE YES					, , ,			
AIDS/HIV+ YES NO	Please check "YES" or "NO)"	Docto	r Comments	Please check "YES" or	"NO"	[Doctor Comments
ANGINA YES								
ANGINA YES NO							NO 🔲	
ARTHRITIS								
ASTHMA YES NO LATEX ALLERGY YES NO BISPHOSPHONATE THERAPY YES NO LIVER PROBLEMS YES NO BLEEDING PROBLEMS YES NO LIVER PROBLEMS YES NO CANCER YES NO LOW BL. PRESSURE YES NO CANCER YES NO PACEMAKER YES NO PSYCHIATRIC CARE YES NO PSYCHIATRIC			NO 🗖		KIDNEY DISEASE			
BISPHOSPHONATE THERAPY YES NO LIVER PROBLEMS YES NO BLEEDING PROBLEMS YES NO LOW BL. PRESSURE YES NO CANCER YES NO LUNG DISEASE YES NO CHEMO/RAD THERAPY YES NO PACEMAKER YES NO COSMETIC SURGERY YES NO PACEMAKER YES NO COSMETIC SURGERY YES NO PACEMAKER YES NO COSMETIC SURGERY YES NO PSYCHIATRIC CARE YES NO COSMETIC SURGERY YES NO PSYCHIATRIC CARE YES NO COSMETIC SURGERY YES NO PSYCHIATRIC CARE YES NO COSMETIC SURGERY YES NO SINUS TROUBLE YES NO COSMETIC SURGERY YES NO SINUS TROUBLE YES NO COSMETIC SURGERY YES NO SINUS TROUBLE YES NO COSMETIC SURGERY YES NO TOBACCO YES NO COSMETIC SURGERY YES NO TOBACCO YES NO COSMETIC SURGERY YES NO THYROID PROBLEMS YES NO TUBERCULOSIS YES N								
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CANCER YES NO LUNG DISEASE YES NO CHEMO/RAD THERAPY YES NO PACEMAKER YES NO COSMETIC SURGERY YES NO PSYCHIATRIC CARE YES NO DIABETES YES NO RHEUMATIC FEVER YES NO DIZZY SPELLS YES NO SINUS TROUBLE YES NO DRUG ADDICTION YES NO SLEEP APNEA YES NO EMPHYSEMA YES NO STROKE YES NO EPILEPSY YES NO STROKE YES NO FAINTING YES NO THYROID PROBLEMS YES NO GLAUCOMA YES NO TUBERCULOSIS YES NO HEART ATTACK/SURGERY YES NO TUBERCULOSIS YES NO HEART MURMUR/PROBLEMS YES NO VENEREAL DISEASE YES NO To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to taking x-rays and an oral examination. Patient's signature Doctor's Signature Date Doctor's Signatur	BLEEDING PROBLEMS	YES 🖵	NO 🗖		LOW BL. PRESSURE	YES 🗆	NO 🗆	
PSYCHIATRIC CARE YES NO	CANCER	YES 🗆				YES 🗖	NO 🗖	
DIABETES YES	CHEMO/RAD THERAPY							
DIZZY SPELLS YES NO SINUS TROUBLE YES NO DELECTION YES NO DELECTION YES NO DESCRIPTION YE								
DRUG ADDICTION YES NO SLEEP APNEA YES NO DEMPHYSEMA YES NO DEMPHYSEMANT								
EMPHYSEMA YES NO TOBACCO YES NO FILE NO STROKE YES STROKE YES NO STROKE YES STROKE								
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FAINTING YES NO THYROID PROBLEMS YES NO HOW THYROID PROBLEMS YES NO HEART ATTACK/SURGERY YES NO TUBERCULOSIS YES NO HEART MURMUR/PROBLEMS YES NO VENEREAL DISEASE YES NO TO THE best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to taking x-rays and an oral examination. Patient's signature Patient is a Minor Doctor Signature Doctor's Signature Doctor's Signature Doctor's Signature Doctor's Signature Dottor's S								
GLAUCOMA YES NO TMD OR TMJ YES NO TUBERCULOSIS								
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HEART MURMUR/PROBLEMS YES NO VENEREAL DISEASE YES NO Details of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to taking x-rays and an oral examination. Patient's signature Patient is a Minor Doctor Signature Doctor Signature Patient's signature Doctor's Signature Doctor's Signature Doctor's Signature Date Doctor's Signature Doctor's Signature Date Doctor's Signature Doctor's Signature Date Doctor's Signature Do	HEART ATTACK/SURGERY	YES 🗆				YES 🗖	NO □	
certify that I consent to taking x-rays and an oral examination. Patient's signature							NO 🗖	
(Parent if Patient is a Minor) Doctor Signature				pletely and accurate	ely. I will inform my dentist of a	any change in m	y health and/o	r medication. I further
Doctor Signature	Patient's signature(Parent if Pa	tient is a M	inor)					
2. Patient's signature Doctor's Signature Date	MEDICAL UPDATE:		Doctor Si	gnature				
2. Patient's signature Doctor's Signature Date				Doctor's Signatur	re		Date	
o. I dilont a signature Date Date	-							

PATIENT INFORMATION

CHART #_____

PATIENT	GETTING TO KNOW YOU
NameLast First	Do you have family members who may need dental care?
Last First	If so, please list name & relationship (son, daughter, husband)
AddressAp	1: 2:
	3:4:
City Zip	
	Talliny Theria (400)
How long at this address?	
Phone ()	
Cell/Pager ()	Billboard (050) Yellow Pages (120) Flyer-Coupon (490) Direct Mail-Postcard (480)
E-mail	Office Sign (420) Internet-Website (190)
Social Security #	
DL#	
Age Birthdate	INSURANCE / DENTAL PLAN
	Primary: Insurance PPO HMO (Circle one)
RESPONSIBLE PARTY (If same as above, ple	
(, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	• ,
Name	Address
Address Ap	· 1
City Zip	
How long at this address?	
Phone ()	Union/Local Group # Plan#
Social Security # DL#	
Relationship to Patient	Birthdate
Age Birthdate	/ INSURANCE / DENTAL PLAN
	Secondary: Insurance PPO HMO (Circle one)
EMPLOYMENT	Plan Name
	Address
Occupation	City, Zip
	Incurance / Plan Phone #
How Long?	Employer
Business Address	Linion/Local Group # Plan#
	Insurad's Nama
Business Phone () Ex	Insured's Soc. Sec. # Birthdate
Verified By Da	
(Office use only)	1. I certify that the information provided is accur
	and will be relied upon for granting credit a providing dental services. I understand that I
DEFEDENCES	tinancially responsible for the charges not cover
REFERENCES	by or paid by my insurance for whatever reason. 2. By signing below, I authorize that you may ver
Name	and exchange information on me and any additio
Phone () Last First	applicants, including requiring reports from cre reporting agencies.
Name	3. I authorize payment directly to the dentist of a
Phone ()	group insurance benefits otherwise payable to me
Spouse's Name	understand that I am financially responsible for a charges not covered by this authorization.
Spouse's Work Phone ()	/ authorize release of any information relating to a
. ,	dental claim or claims. 4. I understand that this dental practice is owned a
DEDCON TO CONTACT FOR FATEROFILOY	operated by an independent dentist. I acknowled
PERSON TO CONTACT FOR EMERGENCY:	that each dentist is individually responsible for dental care provided to me and no other dentist
Last First	corporate entity is responsible for my den
Phone ()	treatment.
	Circulation of Propositivity P. J. P. C. J.
	Signature of Responsible Party or Patient Date