

PATIENT INFORMATION

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*(This i	information is necessary for our files	s and will be considered	CONFIDENTIAL)	
			Dat	
Patient's Name:	First	Age:	Birthday: _	
Residence Address:	rust 5	IIIIIIai	For how long	02
Street	Apt.#	City		A:
If patient is a minor, give name of pa	arent or legal quardian:			
Patient is: Married [☐ Separated	Relationship Widowed	Minor Minor
	Social Security No.	Deparated	s. Phone ()_	
	How Lon			
Employed By:			()	
Person to contact in case of emerge			ne ()	
Who may we thank for referring you			il Address:	
vino may we thank for referring you				
Spouse's Name:				
Employed By:	Occupation:	Bu	s. Phone ()_	
Name of nearest relative not living			Relationship:	
Residence Address:	with you.		Phone ()	
	Apt.#	City	Zip	
	FINIANICIAL IN	ICODMATI	ON	
	- FINANCIAL IN	VIORIVIAII	UN —	
Person responsible for this account			Relationship:	
Address:	Apt.# City	Zip	Phone ()	
PREFERENCE OF PAYMENT:	Cash on day of treatment	☐ Visa No.		
State Aid No.		Mastercard No		
Name of insurance company (prima	any ineurance):			
Name of insurance company (prima	ily insurance).	700		
Insured Person's Name		Birthdate	Relationship	Social Security No.
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Name of Group Dental Plan	Group No.	Plan No.	Name of Union	Local
Name of insurance company (seco	indany insurance):			
Name of insurance company (seco	iluary mourance).			
				0 110 111
Insured Person's Name		Birthdate	Relationship	Social Security No.
Name of Court Delital Disc	Conve No	Di N-	Name of Union	Least
Name of Group Dental Plan	Group No.	Plan No.	Name of Union	Local
	TEDMC 9 C	ONDITION	C	
	- TERMS & C	NOTITON	5	
As a condition of treatment by this of	office, I understand financial arrangements must	be made in advance. The practice	depends upon reimbursemen	t from the patients for the costs
incurred in their care and financial responsibility			openso open contraction	
	ny dental service performed without prior financia			
the dental services furnished to me are charged				
prepare my insurance forms to assist in making of		edit such collections to my accour	t. However, this dental office c	annot render searches on the
the assumption that charges will be paid by an in		to to any destint benefits asserting	a ma undar mu nalinu	
	y authorize my insurance company to pay direct nth (18 % per annum) (but in no event more than			on the unnaid principle halance
on all accounts not paid within 60 days of treatme		The maximum rate permissible of	noci stato towy will be ortal geo	on the angula principle balance
	isted for this dental case can only be extended for	or a period of three months from the	ne date of the patient's examina	ation.
	services rendered to me, or at my request, by th			
said Doctor, or his assignee, at the time said serv				
shall not constitute a waiver of any further term of				t to amounts word by me for
services rendered, the prevailing party in such pr				
	ur assigns, to telephone me at home or at my wo of treatment and agree to their content!	irk to discuss matters pertaining to	this form.	
	t the time of service. Starting July 1, 2007, we wi	ill be charging \$10 fee per stateme	ent for each outstanding accoun	nt.
The dan that you pay for your visit a	to all of solving. Calling only 1, 2007, we will	in the strongling who ree per statelling	Patient or Parent/Guardian In	
- Please be aware that there will be a	a charge for any broken appointments without 24	hour notice. Fee will be maximun		
			Patient or Parent/Guardian Ir	nitials X

(Continued on Other Side)

Parent's/ Guardian's Signature if Patient is Minor.



SIGNATURE OF PATIENT, PARENT, or GUARDIAN

MEDICAL HISTORY

DATE

Do you have, or have had, any of the following? AIDS/HIV Positive Yes No Diabetes Yes No Diabetes Yes No Hepatitis A Yes No Recent Weight Loss Yes Anaphylaxis Yes No Drug Addiction Yes No Hepatitis B or C Yes No Real Dialysis Yes Anaphylaxis Yes No Easily Winded Yes No Hepatitis B or C Yes No Real Dialysis Yes Anthritis/Gout Yes No Emphysema Yes No High Blood Pressure Yes No Reheumatism Yes Arthrifis/Gout Yes No Excessive Bleeding Yes No High Cholesterol Yes No Arthritis/Gout Yes No Excessive Bleeding Yes No Hives or Rash Yes No Sickle Cell Disease Yes No Real Dialysis Yes No Remail Disease Yes No Remail Dis							
Have you ever had a serious head or neck nijury? Yes No If yes, please explain: Have you ever had a serious head or neck nijury? Yes No If yes, please explain: Are you taking any medications, pills, or drugs? Yes No Have you take, or have hot on a special diet? Yes No Are you as pecial diet? Yes No Do you use tobacco? Yes No Do you use tobacco? Yes No Do you use tobacco? Yes No Are you allergic to any of the following? Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa of Other If yes, please explain: Do you have, or have had, any of the following? AlDSHIV Positive Yes No Dubetes Yes No Hepatits A Yes No Hepatits B or Yes No Ranghylaxis Yes No Emphysema Yes No Hepatits B or Yes No Ranghylaxis Yes No Emphysema Yes No Hepatits B or Yes No Ranghylaxis Yes No Emphysema Yes No Hepatits B or Yes No Ranghylaxis Yes No Emphysema Yes No Hepatits B or Yes No Ranghylaxis Yes No Emphysema Yes No Hepatits B or Yes No Ranghylaxis Yes No Friequert Diamhes Yes No Hepatits A Yes No No Ranghylaxis Yes No Excessive Bleeding Yes No No Helpatits A Yes No No Ranghylaxis Yes No Friequert Diamhes Yes No No Helpatits Yes No No Helpatits A Yes No No Ranghylaxis Yes No Priequert Diamhes Yes No No Helpatits Yes No No Helpatits A Yes No No Ranghylaxis Yes No Priequert Diamhes Yes No No Helpatits Yes No No Helpatits Yes No No Helpatits A Yes No Helpatits A Yes No No Helpatits A Yes No Helpatits A Yes No No Helpatits A Yes No Helpatits A Yes No No Helpatits A Yes No H	have, or medication that you may be	eat the area in and aroun taking could have an impo	d your mouth, portant interrelat	your mouth is a pa ionship with the de	rt of your entire b entistry you will re	ody. Health problems ceive. Thank you for	s that you may answering the
Have you ever had a serious head or neck injury? Yes No If yes, please explain: Are you taking any medications, pills, or drugs? Yes No Have you taken, Phen-Fen or Redrux? Yes No Have you ever taken Fosamax, Boniva, Actonel or anyother medications containing bisphosphonates? Yes No Do you use tobacco? Yes No Do you use tobacco? Yes No Do you use tobacco? Yes No Do you use controlled substances? Yes No Do you use controlled substances? Yes No Do you use controlled substances? Yes No Pregnant? Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No Are you allergic to any of the following? Aspirin Penicitiin Codeine Local Anesthetics Acrylic Metal Latex Sulfa de Codeine If yes, please explain: Do you have, or have had, any of the following? Albishir Pealswe Yes No Corisone Medicine Yes No Hepatits & Yes No Hepatits & Yes No Recent Weight Loss Yes Anaphylaxis Yes No Dabetes Yes No Hepatits & Code No Recent Weight Loss Yes No Angina Yes No Emphysiema Yes No Emphysiema Yes No Emphysiema Yes No Hepatits & Yes No Hepatits & Yes No Hepatits & Yes No Anterias Odd Yes No Emphysiema Yes No Hepatits & Yes No He	Are you under a	physician's care now?	Yes No	o If yes, please	explain:		
Have you ever had a serious head or neck injury? Yes No If yes, please explain: Are you taking any medications, pills, or drugs? Yes No Have you taken, Phen-Fen or Redrux? Yes No Have you ever taken Fosamax, Boniva, Actonel or anyother medications containing bisphosphonates? Yes No Do you use tobacco? Yes No Do you use controlled substances? Yes No Do you use controlled substances? Yes No No Prenant Trying to get pregnant? Yes No Taking oral contraceptives? Yes No No Nursing? Yes No Areyou allergic to any of the following? Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa de Control of the following? Alberthy Fositive Yes No Corrisone Medicine Yes No Hepatitis Bor Control of Yes No Recent Weight Loss Yes Anaphylixas Yes No Dupu Addiction Yes No Hepatitis Bor Control of Yes No Recent Weight Loss Yes No Angina Yes No Emphysiema Yes No Hepatitis Bor Control Yes No Retail Displays Yes No Anthritis Glout Yes No Emphysiema Yes No Hepatitis Problem Yes No Scarker Fever Yes No Hepatitis No Yes No Hepatitis No Scarker Fever Yes No Hepatitis No Yes No Hepatitis No Yes No Scarker Fever Yes No Hepatitis No Yes No Hepatitis No Yes No Scarker Fever Yes No Hepatitis No				o If ves. please	explain:		
Are you taking any medications, pills, or drugs? Yes No Do you take, or have you taken, Phen-Fen or Redux? Yes No Have you ever taken Fosamax, Boniva, Actonel or anyother medications containing bisphosphonates? Yes No Do you use tobacco? Yes No Are you on a special diet? Yes No Do you use controlled substances? Yes No Are you allergic to any of the following? Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa d Other If yes, please explain: Do you have, or have had, any of the following? Albishir Postive Yes No Alchemer's Disease Yes No Drug Addiction Yes No Araenia Yes No Araenia Yes No Araenia Yes No Angina Yes No Essly Winded Yes No Arificial Heart Valve Yes No Artificial Heart Valve Yes No Blood Disease Yes No No Erious Project Headsches Presult Herpost Yes No Rocarter Fever Yes No Artificial Heart Valve Yes No Rocarter Fever No Rocarter Fever Yes No Rocarter Fever Yes No Rocarter Rever Yes No Rocarter Rever Yes No Rocarter Rever Yes No Rocarter Rever No Rocarter Rever Yes No Rocarter Rever Yes No Rocarter Rever							
Do you take, or have you taken, Phen-Fen or Redux? Yes No Have you ever taken Fosamax, Boniva, Actonel or anyother medications containing bisphosphonates? Yes No Do you use tobacco? Yes No Do you use tobacco? Yes No Do you use controlled substances? Yes No Do you use controlled substances? Yes No Are you allergic to any of the following? Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa d Other If yes, please explain: Do you have, or have had, any of the following? Albshirt Postive Yes No Alzhemer's Disease Yes No Do Joud Addiction Yes No Anemia Yes No Anemia Yes No Angina Yes No Angina Yes No Angina Yes No Epilepsy or Seizures Yes No Arthrical Heart Valve Yes No Arthrical Heart Valve Yes No Asthman Yes No Blood Disease Yes No Braching Problem Yes No Conyclosine Wern No Conyclosine Metal Latex Sulfa d Wes No Braching Problem Yes No Conyclosine Metal Latex Sulfa d Wes No Braching Addiction Yes No Asthman Yes No Frequent Cough Yes No Conyclosine Metal Latex Sulfa d Wes No Braching Addiction Yes No Scarlet Fever No Scarlet							
Have you ever taken Fosamax, Boniva, Actonel or anyother medications containing bisphosphonates? Yes No Do you use tobacco? Yes No Do you use controlled substances? Yes No Women: Are you Pregnant/ Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Are you allergic to any of the following? Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa d Other If yes, please explain: Do you have, or have had, any of the following? Albi-hir Positive Yes No Dabetes Yes No Hemphilis Yes No Raphylaxis Yes No Hemphilis Bor C Yes No Renal Dialysis Yes Angina Yes No Easily Winded Yes No Hepatitis Bor C Yes No Renal Dialysis Yes Angina Yes No Englepsy or Seizures Yes No High Blood Pressure Yes No Anthicial John Yes No Excessive Bleeding Yes No High Glode Pressure Yes No High Cholesterol Yes No Singles Anthicial John Yes No Fraquent Cough Yes No Inguis Practical Yes No Branting Spelis/Dizziness Yes No Inguis Practical Yes No Singles Presume Yes No Branting Problem Yes No Fraquent Cough Yes No Inguis Brood Pressure Yes No Inguis Trouble Yes No Branting Problem Yes No Genital Herpes Yes No Low Blood Disease Yes No Chemotherapy Yes No Genital Herpes Yes No Low Brood Pressure Yes No Depatition Yes No Genital Herpes Yes No Low Blood Pressure Yes No Trying Disease Yes No Chemotherapy Yes No Heart Provided Yes No Depatition Yes No Genital Herpes Yes No Low Blood Disease Yes No Chemotherapy Yes No Heart Provided Yes No Depatition Yes No Heart Provided Yes No Depatition Yes No Heart Provided Yes No Depatition Yes No Heart Provided Yes No Paralytyroid Disease Yes No Trying Disease Yes No Congenital Heart Discreter Yes No Heart Provided Disease Yes No Heart Provided Disease Yes No University of Disease Yes No University of Disease Yes No University of Disease Yes No Trumors or Growths Yes No Congenital Heart Discreter Yes No Heart Provide Disease Yes No Heart Provided Booke? Yes No Heart Provided Booke? Yes No Paralytyroid Disease Yes No University of Disease Yes No Heart Provided Booke? Yes No Paralyt					explain:		
Are you on a special diet? Yes No Do you use controlled substances? Yes No Do you use controlled substances? Yes No Women: Are you Pregnant/ Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Are you allergic to any of the following? Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa d Other If yes, please explain: Do you have, or have had, any of the following? AllShirty Positive Yes No Dubatels Yes No Hepothila Yes No Hepatitis A Yes No Racent Weight Loss Yes Anaphylaxis Yes No Duby Addiction Yes No Hepatitis A Yes No Recent Weight Loss Yes Anaphylaxis Yes No Early Winded Yes No Hepatitis Bor C Yes No Recent Weight Loss Angina Yes No Eigheysena Yes No Hepatitis Bor C Yes No Remailian Fever Yes AnthribisCout Yes No Eigheyser Service Bleding Yes No High Blood Pressure Yes No Scarlet Fever Yes AnthribisCout Yes No Excessive Bledding Yes No High Cholesterol Yes No Scarlet Fever Yes AnthribisCout Yes No Excessive Bledding Yes No High Blood Pressure Yes No Sickle Cell Disease Yes No Finding Spells/Dizzness Yes No Love Blood Pressure Yes No Sinus Trouble Yes Blood Transfusion Yes No Frequent Diamhea Yes No Love Blood Pressure Yes No Sinus Trouble Yes No Remainable Yes No Cancer Yes No Glaucoma Yes No Love Blood Pressure Yes No Turberculosis Yes No Congenia Heart Disorder Yes No Heart Murmur Yes No Despense Yes No Love Blood Pressure Yes No Turberculosis Yes No Congenia Heart Disorder Yes No Heart Trouble/Disease Yes No Mural Valve Problems Yes No Turberculosis Yes No Convolvisions Yes No Heart Trouble/Disease Yes No Pychaintic Care Yes No No No Turbors of Growths Have you ever had any serious illness not listed above? Yes No Pychaintic Care Yes No No Heart Trouble/Disease Yes No Pychaintic Care Yes No No Heart Trouble/Disease Yes No Pychaintic Care Yes No No Heart Trouble/Disease Yes No Pychaintic Care Yes No No Heart Trouble/Disease Yes No Pychaintic Care Yes No No Heart Trouble/Disease Yes No Pychaintic Care Yes No No Heart Trouble/Disease Yes No Pychaintic Care Yes No No Heart	Do you take, or have you taken	, Phen-Fen or Redux?	Yes No	-			
Do you use tobacco? Yes No Do you use controlled substances? Yes No Women: Are you Pregnant? Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No Are you allergic to any of the following? Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa d Other If yes, please explain: Do you have, or have had, any of the following? AlDSHIV Positive Yes No Diabetes Yes No Hempstilis A Yes No Alzheimer's Disease Yes No Diabetes Yes No Hepstilis B or C Yes No Anaphylaxis Yes No Diabetes Yes No Hepstilis B or C Yes No Angina Yes No Emphysema Yes No Hepstilis B or C Yes No Arthritis/Gout Yes No Emphysema Yes No High Blood Pressure Yes No Arthritis/Gout Yes No Excessive Pitners Yes No Hives or Rash Yes No Asthma Yes No Excessive Pitners Yes No Herpitos Result Yes No Asthma Yes No Excessive Pitners Yes No Hives or Rash Yes No Sinual Frouble Yes No Asthma Yes No Frequent Cough Yes No Kidney Problems Yes No Sinual Frouble Yes No Renational Pressure Yes No No Renational Yes No Excessive Pitners Yes No Hives or Rash Yes No Sinual Frouble Yes No Renational Problem Yes No Renational Problems Yes No Cantel Fever Yes No Renational Problems Yes No Cantel Fever Yes No Cantel Fever Yes No Cantel Fever Yes No Cantel Fever Yes No Cancer Yes No Genital Herpes Yes No Leukemia Yes No Sinual Frouble Yes No Cancer Yes No Genital Herpes Yes No Low Blood Pressure Yes No Tonsilitus Yes No Congental Heard Ack/Failure Yes No Mitral Valve Prolapse Yes No Tonsilitus Yes No Congental Heard Disorder Yes No Heart Murmur Yes No Parathyroid Disease Yes No Uncers Yes No Heart Murmur Yes No Parathyroid Disease Yes No Uncers Yes No Heart Murmur Yes No Parathyroid Disease Yes No Uncers Yes No Heart Murmur Yes No Parathyroid Disease Yes No Uncers Yes No Heart Murmur Yes No Parathyroid Disease Yes No Uncers Yes No Heart Murmur Yes No Parathyroid Disease Yes No Uncers Yes No Heart Murmur Yes No Parathyroid Disease Yes No Uncers Yes No Heart Murmur Yes No Parathyroid Disease Yes No Uncers Yes No Uncers Yes No Hear			Yes No	· —			
Women: Are you Pregnant/ Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No Nur	Are	you on a special diet?	Yes No	0			
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	Comments:						
*To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information car dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.	*To the best of my knowledge, the qu	uestions on this form have	been accurate	ely answered. I und	derstand that prov	iding incorrect inform	ation can be