

ABOUT YOU

Today's Date:	E-mail Address:	
	I prefer to be called: Male 🗋 Female	
	ur mrs ms Dr	
Home Address:	City State Zip ork Phone #: () Ext: Driver License #:	
	Whom may we Thank for referring you?	
Other family members seen by us:		
	How long there? Occupation:	
England Address		
Street/PO Box	City State Zip Relative not living with you	
His / Her Name: Relation:	Work Phone #: () Home Phone #: ()	
Address:Street	A). A	
	City State Zip	
Person Responsible	for Account if other than yourself	
	Home Phone #: () Social Security #:	
	Ext: Drivers License #:	
Billing Address:	City State Zip	
SPOUSE INFORMATION		
His / Her Name	Birthdate:// Social Security #:	
	Vork Phone #: () Ext: Drivers License #:	
· ·		
INSURANCE INFORMATION		
Primary Insurance Dental Coverage? 🗆 Yes 🗔 No	Medical Coverage? 🗆 Yes 🗔 No 🛛 Orthodontic Coverage? 🗔 Yes 🗔 No	
Insurance Co. Name: Phone #	() Group # (Plan, Local or Policy #):	
Insurance Co. Address:	City State Zio	
Street/PO Box Insured's Name: Insured's Social Sec		
Insured's Employer: Employer's Address	Street/PO Box City State Zip	
	Street/PO Box City State Zip	
Secondary Insurance Dental Coverage? Yes No Me	dical Coverage? 🗋 Yes 🗋 No Orthodontic Coverage? 🗋 Yes 🗋 No	
Insurance Co. Name: Phone #	: () Group # (Plan, Local or Policy #):	
Insurance Co. Address:	City State Zip	
Insurance Co. Address:	City	
Insurance Co. Address:	City	

Wey have you came to the dentist boday?	DENTA	L HISTORY	
Ade you carefully in pairs IN Do you and adde hardward in the interment? IN Do you and adde hardward interment? IN Do you and adde interment? IN Media Usat IN Me you and with dense operation of physiciant? IN Me you and with dense operation of physiciant? IN Me you and with dense operation of physiciant? IN Me you and with dense operation of physiciant? IN Me you and with dense operation of physiciant? IN Me you and with dense operation of physiciant? IN Me you and addition of physiciant? IN Me you and addition of physician	Why have you come to the dentist today?	_ Do your gums ever bleed? 🔲 Yes 🛄 No 🛛 Ever Itch? 🗋 Yes 🛄 No	
Do you set where a product address and chard mathematical product with the you can find where you are address to bed, and where where the set of the product with the you can find where where you can address to bed, and where where we want where the way out and the way way are address to bed, and way way way and the set of the product with the way way are address to bed, and way way way and the set of the product with the way way are address to be way and the set of the product way way are address to be way and the set of the product way way are address to be way and the set of the product way way are address to be way and the set of the product way way are address to be way and the set of the product way way are address to be way and the set of the product way way are address to be way and the set of the product way way are address to be way and the set of the product way way are address to be way and the set of the product way way are address to be way and the set of the product way way are address to be way and the set of the product way way are address to be way and the set of the product way way are address to be way and the set of the product way way are address to be way and the set of the product way way are address to be way and the set of the product way way are address to be way and the set of a physicine the set of the set of a physicine the set of a physicine the set of a physici		_ Have you ever had periodontal disease?	
there you spectraced problem subclick with a province of the sequence of the sequen	Are you currently in pain?	Do you have mobility in your teeth?	
ary provise double work?	Do you require antibiotics before dental treatment? 🛛 🗋 Yes 🗔 No	Are your teeth sensitive to heat, cold, or anything else?	
De you now of mere you are instanced pain / ducated pain / ducate	any previous dental work? 🔲 Yes 🛄 No		
Turn carrent dealth health is			
Type of bitalles on your tookhoukitik I Hord I Medium Seff How log do you use a bothoukitik protochouk before replacing R Image: Construction of the construction		Or (Please Circle)	
How long do you use a soldhowh before replacing if? Image: the solution of the s			
De you so onlyking in addition to your bruch and floss? \response of the following? \response of the following? Would you like finable bracht? Yes No Would you like finable bracht? Yes No Metanonal State \response of the following? Yes No Physiciant's Name		H What did you like most & least about any dentist you have seen?	
Eyes, what?			
Wood you like freaker breaker? Y Writer teaker? Y No Do you have a personal physican? Y is a production? Y Y Y Solid Drugs Physican's Name:			
MEDICAL HISTORY Da you have a personal physician? \" here \" here diat visit:			
Do you have a personal physician? Iver our affective any of the following? Y N Solida Drugs Physician's Name:			
Physician's Name:			
Address: Phone #: Y N Y N V N	Do you have a personal physician? 🗆 Yes 🗔 No 🛛 Date of last visit:	Are you allergic to any of the following?	
Are you currently under the care of a physician? Image: the care of a physician? Image: the care of a physician? Please explain: Do you smoke or us tobacco in any other form? Image: the care of a physician? Image: the care of a physician? Do you smoke or us tobacco in any other form? Image: the care of a physician? Image: the care of a physician? Image: the care of a physician? How you been told that you snore or hold your breath while alleging or works up gapping for breath? Image: the care of a physician? Image: the care of a physician? Image: the care of a physician? Y N Acetaminophen Y N Blood Thimmers Y N Insulin/Didates Drugs Y N Thyroid Medicine Y N Analysinin Y N Blood Thimmers Y N Insulin/Didates Drugs Y N Thyroid Medicine Y N Anthitstomines Y N Blood Thimmers Y N No No N A athitistomines Y N Digital/Hear Medication Y N No No No N A Athitistomines Y N Calis Y N Hear Attock Y N No No N A Athitistomines Y N Didital/Backing Y N Hear Attock Y N	Physician's Name:	Y N Aspirin Y N Erythromycin Y N Sedatives Y N Barbiturates Y N Jewelry / Metals Y N Sulfa Drugs	
Are you currently under the care of a physician? Image: the care of a physician? Image: the care of a physician? Please explain: Do you smoke or us tobacco in any other form? Image: the care of a physician? Image: the care of a physician? Do you smoke or us tobacco in any other form? Image: the care of a physician? Image: the care of a physician? Image: the care of a physician? How you been told that you snore or hold your breath while alleging or works up gapping for breath? Image: the care of a physician? Image: the care of a physician? Image: the care of a physician? Y N Acetaminophen Y N Blood Thimmers Y N Insulin/Didates Drugs Y N Thyroid Medicine Y N Analysinin Y N Blood Thimmers Y N Insulin/Didates Drugs Y N Thyroid Medicine Y N Anthitstomines Y N Blood Thimmers Y N No No N A athitistomines Y N Digital/Hear Medication Y N No No No N A Athitistomines Y N Calis Y N Hear Attock Y N No No N A Athitistomines Y N Didital/Backing Y N Hear Attock Y N	Address: Phone #: ()	_ Y N Codeine Y N Latex Y N Tetracycline	
Please explain:			
De you snake or use tobacco in any other form? I'Yis I'No For Women: Are you taking birth control pills? I'Yes No How you even take up againg to breath while sleping or wake up againg to breath while sleping or wake up againg to breath while it is the strict or take up and the strict or take up and the strict or the strict		Please list additional drugs/materials that cause allergic reactions:	
Here you been told havy ou save to ked you breath while sheeping or wake up gapping for breath Hore you were taken foxmax, or any other Bisphosphonate? Y is Yes No Are you program? Wask #: Are you nursing? Y is Yes No Are you program? Y is Yes No Wask #: Are you nursing? Y is Y is Yes No Y is Y is Actaminophen Y is Anthistomines Y is Yes No Are you nursing? Y is Yes No Are you taking any prescription, over-the-counter drugs, harbot remedies, vitamins or minerals not listed abors? Y is Yes No if yes, please list each one: Y is Yes No V is Actinitia drukes Y is Yes Opu or have you experienced the following? Y is Yes No if yes, please list each one: Y is Yes No if yes, please list each one: Y is Yes No if yes, please list each one: Y is Yes No if yes, please list each one: Y is Yes No if yes, please list each one: Y is Yes No if yes, please list each one: Y is Yes No if yes, please list each one: Y is Yes No if yes, please Y is Yes No			
Hove you ever taken Fosamax, or any other Bisphosphonate? Image: Second Sec		For Women: Are you taking birth control pills?	
Are you taking any of the following? Y N Acetaminophen Y N N Acetaminophen Y N N No			
Y N Acetaminophen Y N Blood Thinners Y N No. Y N No. Y N No. No. <t< td=""><td>Have you ever taken Fosamax, or any other Bisphosphonate? 🔲 Yes 🛄 Ne</td><td>Week #: Are you nursing?</td></t<>	Have you ever taken Fosamax, or any other Bisphosphonate? 🔲 Yes 🛄 Ne	Week #: Are you nursing?	
Do you or have you experienced the following? Y N Abnormal Bleeding Y N Cangenidal Heart Defect Y N Headachas Y N Liver Disease Y N Seizures Y N Anamia Y N Cangenidal Heart Defect Y N Headachas Y N Liver Disease Y N Siziares Y N Anamia Y N Difficulty Breathing Y N Headachas Y N Liver Disease Y N Siziares Y N Antificial Bones/Joints Y N Difficulty Breathing Y N Headachas Y N Mitrol Volve Prolopes Y N Siziares Y N Antificial Bones/Joints Y N Difficial Bones/Joints N Difficial Bones/Joints N N <td>Y N Acetaminophen Y N Antibiotics Y N Antibistamines Y N Cold Remedies</td> <td>Y N Insulin/Diabetes Drugs Y N Nitroglycerin Y N Recreational Drugs</td>	Y N Acetaminophen Y N Antibiotics Y N Antibistamines Y N Cold Remedies	Y N Insulin/Diabetes Drugs Y N Nitroglycerin Y N Recreational Drugs	
Y N Abnormal Bleeding Y N Collits Y N Congenital Heart Defact Y N Longenital Heart Defact Y N Heart Mumur Y N Longenital Heart Defact Y N Heart Mumur Y N Longenital Heart Mumur Y N Longenital Heart Mumur Y N Sicule Cell Disease Y <	Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamins o	minerals not listed above? 🗆 Yes 🗔 No If yes, please list each one:	
Y N Abnormal Bleeding Y N Collits Y N Congenital Heart Defact Y N Longenital Heart Defact Y N Heart Mumur Y N Longenital Heart Defact Y N Heart Mumur Y N Longenital Heart Mumur Y N Longenital Heart Mumur Y N Sicule Cell Disease Y <	Do you or have you experienced the following?		
I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. My method of payment will be I certify that I am covered by Insurance I number of services rendered and also responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. Signature Date PAYMENT IS DUE AT TIME OF SERVICE Date Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA. Signature Date	Y N Abnormal Bleeding Y N Colitis Y N Y N Alcohol Abuse Y N Congenital Heart Defect Y N Y N Anemia Y N Diabetes Y N Y N Arthritis Y N Difficulty Breathing Y N Y N Arthritical Bones/Joints Y N Drug Abuse Y N Y N Artificial Valves Y N Emphysema Y N Y N Asthma Y N Epilepsy Y N Y N Blood Transfusion Y N Fainting Spells Y N Y N Chemotherapy Y N Glaucoma Y N Y N Chicken Pox Y N Hay Fever Y N	Headaches Y N Liver Disease Y N Seizures Heart Attack Y N Low Blood Pressure Y N Shingles Heart Attack Y N Lupus Y N Sickle Cell Disease Heart Surgery Y N Mitral Valve Prolapse Y N Sinus Problems Hemophilia Y N Osteoporosis/Paget's Disease Y N Steroid Therapy Hepatitis Y N Pacemaker Y N Stroke Herpes Y N Persistent Cough Y N Thyroid Problems High Blood Pressure Y N Psychiatric Treatment Y N Tonsillitis HIV+/AIDS Y N Radiation Treatment Y N Tuberculosis (TB) Hospitalized for Any Reason Y N Rheumatic Fever Y N Ulcers	
knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. My method of payment will be (Co. and I assign directly to Dr all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.	AUTH	DRIZATIONS	
PAYMENT IS DUE AT TIME OF SERVICE Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA. Signature Date	knowledge. It will be held in the strictest confidence and it is m responsibility to inform this office of any changes in my medical statu I authorize the dental staff to perform the necessary dental service	y Co. and I assign directly to Drall insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature	
standards of infection control mandated by OSHA, the CDC and the ADA. Signature Date	PAYMENT IS DUE AT TIME OF SERVICE	on all my insurance submissions, whether manual or electronic.	
FORM # A2C0197-V8 www.informsonline.com © 2014 INFORMS 1-800-722-4884		Signature Date	
	FORM # A2C0197-V8 www.inform	conline.com © 2014 INFORMS 1-800-722-4884	