## 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 Information   CONFIDENTIAL   Date   Home Phone   State!   Fro.   P.C.							
Name   Birthdate   Home   Address   City   Prov.   P	Patient Inform						
Address   City   State   ZpC   Email   Check Appropriate Box   Minor   Single   Married   Divorced   Widowed   Separated   Student, Name of School/College   City   Prov.   Time   Time   Business Address   City   Prov.   Time   Time   Work Phone   Student, Name of School/College   City   Prov.   Prov.   Business Address   City   Prov.   Prov	9			Home Phone			
Email   Cell Phone   Separated   Studen, Name of School/College   City   Prov.   Time   Time				State/	Zip/		
Check Appropriate Box:   Minor   Single   Married   Divorced   Widowed   Separated   Statef   Full   Part   Statef   Work   Phone   Time   Tim							
Patient or Parent/Guardian's Employer Business Address   City   Prov   P							
Patient or Parent/Guardian's Employer Business Address   City   Prov   P	If Student. Name of School/Colleg	e	City	State/ Prov	□ Full □ Time □ Time		
Business Address City Prov PC.  Spouse or Parent/Guardian's Name Employer Work Phone  Whom may we thank for referring you?  Person to contact in case of emergency Phone  Responsible Party  Name of Person Responsible for this Account to Patient Phone Cell Phone  Email Cell Phone Priver's License# Birthdate Financial Institution  Employer Work Phone SS#/SIN Is this person currently a patient in our office? Yes No  For your convenience, we offer the following methods of payment. Please check the option you prefer Payment in full at each appointment.  Cash Personal Check Credit Card VISA MasterCard I wish to discuss the offices payment policy.  Insurance Information  Name of Insured SS#/SIN Date Employed  Name of Employer City State Floor  How much is your deductible? How much have you used? Max. annual benefit  DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No If YES, COMPLET THE FOLLOWING:  Name of Insured Birthdate SS#/SIN Date Employed  Work Phone State Prov. Prov.  Fig. 100 Yes, Company Date Employed  Work Phone State Prov.  Fig. 100 Yes, Company Date Employed  Work Phone State Prov.  Fig. 100 Yes, Company Date Employed  Work Phone State Prov.  Fig. 100 Yes, Company Date Employed  Work Phone State Prov.  Fig. 100 Yes, Company Date Employed  Work Phone State Prov.  Fig. 100 Yes, Company Date Employed  Work Phone State Prov.  Fig. 100 Yes, Company Date Employed  Work Phone State Prov.  Fig. 100 Yes, Company Date Employed  Work Phone Date Employed  Work Phone State Prov.  Fig. 100 Yes, Company Date Employed  Work Phone Date Employed	Patient or Parent/Guardian's Emr.	ployer		Work Phone			
Spouse or Parent/Guardian's Name	Business Address		City	State/ Prov	Zip/ P.C		
Whom may we thank for referring you?  Person to contact in case of emergency  Responsible Party  Name of Person Responsible for this Account  Address  Home Phone  Cell Phone  Driver's License#  Birthdate  Employer  Work Phone  SS#/SIN  Is this person currently a patient in our office? Yes No  For your convenience, we offer the following methods of payment. Please check the option you prefer Payment in full at each appointment.  Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy.  Insurance Information  Relationship  to Patient  Birthdate  SS#/SIN  Date Employer  City  Prov  PC.  How much is your deductible?  How much have you used?  Name of Insured  DO YOU HAVE ANY ADDITIONAL INSURANCE?  Very  Very  Very  Name of Employer  Lorion or Local#  State/ Prov  PC.  How much is your deductible?  Name of Insured  SS#/SIN  Date Employed  Max. annual benefit  DO YOU HAVE ANY ADDITIONAL INSURANCE?  Very  Very  Very  Very  Name of Employer  Lorion or Local#  State/ Prov  PC.  How much have you used?  Max. annual benefit  DO YOU HAVE ANY ADDITIONAL INSURANCE?  Very  Very  Very  Name of Employer  Lorion or Local#  State/  Very  Very  Name of Employer  Lorion or Local#  State/ Prov  PC.  How much is your deductible?  Union or Local#  Work Phone  State/ Prov  PC.  Insurance Company  Group#  Dote Employed  Name of Employer  Address of Employer  Union or Local#  Work Phone  State/ Prov  PC.  Insurance Company  Group#  Policy/ID#  State/ Prov  PC.  Pro							
Person to contact in case of emergency			N. 200				
Name of Person Responsible for this Account  Address							
Name of Person Responsible for this Account  Address							
Address	-	•		Relationship			
Email							
Driver's License#_ Birthdate							
Employer							
Is this person currently a patient in our office?  \[ \text{Yes} \] \  \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \							
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.    Cash   Personal Check   Credit Card   VISA   MasterCard   I wish to discuss the office's payment policy.    Insurance Information   Relationship to Patient							
□ Cash □ Personal Check				efer. Pavment in full at eac	h appointment.		
Insurance Information  Name of Insured SS#/SIN Date Employed Name of Employer City Prov. P.C.  Insurance Company Group# Prov. P.C.  How much is your deductible? How much have you used? Max. annual benefit DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:  Name of Employer Union or Local# Work Phone State Zip/ Prov. P.C.  How much is gour deductible? How much have you used? Max. annual benefit DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:  Name of Insured Birthdate SS#/SIN Date Employed Name of Employer Union or Local# Work Phone State/ Zip/ Prov. P.C.  Address of Employer Gity Prov. P.C.  Insurance Company Group# Policy/ID# State/ Zip/ Prov. P.C.  Insurance Company Group# Policy/ID# State/ Zip/ Prov. P.C.					A		
Name of Insured SS#/SIN Date Employed Name of Employer Union or Local# Work Phone State/ Zip/ Prov. P.C.  Insurance Company Group# Policy/ID# State/ Zip/ Prov. P.C.  How much is your deductible? How much have you used? Max. annual benefit DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:  Name of Insured SS#/SIN Date Employed Name of Employer Union or Local# Work Phone State/ Zip/ Prov. Pro	Insurance Info	rmation		<b>2</b>			
Birthdate SS#/SIN Date Employed Name of Employer Union or Local# Work Phone State/ Zip/ Prov. P.C.  Insurance Company Group# Policy/ID# State/ Zip/ Prov. P.C.  Ins. Co. Address City Prov. P.C.  How much is your deductible? How much have you used? Max. annual benefit DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:  Name of Insured SS#/SIN Date Employed Name of Employer Union or Local# Work Phone State/ Zip/ Prov. P.C.  Address of Employer City Prov. P.C.  Insurance Company Group# Policy/ID# State/ Zip/ Prov. P.C.  Insurance Company Group# Policy/ID# State/ Zip/ Prov. P.C.  City Prov. P.C.	The second secon			Relationship			
Name of Employer Union or Local# Work Phone State/ Zip/ Prov PrC.  Insurance Company Group# Policy/ID# State/ Zip/ Prov PrC.  How much is your deductible? How much have you used? Max. annual benefit DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:  Name of Insured Relationship to Patient be Patient to Patient to Patient Date Employed Union or Local# Work Phone State/ Zip/ Prov PrC.  Address of Employer City Prov PrC.  Insurance Company Group# Policy/ID# State/ Zip/ Prov PrC.  Insurance Company Group# Policy/ID# State/ Zip/ Prov PrC.							
Address of Employer City Prov. P.C.  Insurance Company Group# Policy/ID# State/ Zip/ Ins. Co. Address City Prov. P.C.  How much is your deductible? How much have you used? Max. annual benefit  DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:  Name of Insured Relationship to Patient  Birthdate SS#/SIN Date Employed  Name of Employer Union or Local# Work Phone State/ Zip/ Prov. P.C.  Insurance Company Group# Policy/ID# Ins. Co. Address City Prov. P.C.  State/ Zip/ Prov. P.C.				- DOMESTIC CONTRACTOR OF STANCE AND ADDRESS			
Insurance Company Group# Policy/ID#				State/	Zip/		
Ins. Co. Address City State/ Prov					P.C		
How much is your deductible? How much have you used? Max. annual benefit  DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:  Name of Insured Relationship to Patient  Birthdate SS#/SIN Date Employed  Name of Employer Union or Local# Work Phone State/ Zip/ Prov. P.C.  Insurance Company Group# Policy/ID# State/ Zip/ Prov. P.C.  Ins. Co. Address City Prov. P.C.	SEC. (50)			Statel	Zip/		
DO YOU HAVE ANY ADDITIONAL INSURANCE?  Name of Insured							
Name of Insured         Relationship to Patient           Birthdate         SS#/SIN           Name of Employer         Union or Local#         Work Phone State/ Zip/ Prov. P.C.           Address of Employer         City         Prov. P.C.           Insurance Company         Group#         Policy/ID# State/ Zip/ Prov. P.C.           Ins. Co. Address         City         Prov. P.C.	How much is your deductible? _	How much	have you used?	Max. annual benefi	t		
Birthdate         SS#/SIN         Date Employed           Name of Employer         Union or Local#         Work Phone           State/         Zip/           Prov.         P.C.           Insurance Company         Group#         Policy/ID#           Ins. Co. Address         City         Prov.         P.C.	DO YOU HAVE ANY ADDITIO	ONAL INSURANCE?	es □ No IF YES, 0	COMPLETE THE FOLLO	WING:		
Name of Employer         Union or Local#         Work Phone	Name of Insured			Relationship to Patient			
Address of Employer         City         State/Prov.         Zip/Prov.         P.C.	Birthdate	SS#/SIN		Date Employe	d		
Insurance Company         Group#         Policy/ID#           Ins. Co. Address         City         Prov.         P.C.	Name of Employer		Union or Local#	Work Phone _	147		
Insurance Company         Group#         Policy/ID#           Ins. Co. Address         City         Prov.         P. C.				State/			
Ins. Co. Address City Staté/ Zip/ Prov. P.C				Policy/ID#	- 1 Table 1		
				Statel	Zip/ _P.C		
		How much h					

1. Are you under medical treatment no										No
	nv?		Yes	No	10. Are	e you w	vearing	contact lenses?	Yes	
2. Have you ever been hospitalized for			72-25					have you had any reactions to the following?	_	-
surgical operation or serious illness	within the le	ast 5 years?			Loc	al Ane	sthetics	(e.g. Novocain)	- H	_
If yes, please explain		9		Pen	ta Da	or any o	other Antibiotics	. H	-	
					Suij	ja Druž dinova	gs rec		H	-
3. Are you taking any medication(s)	-		1							
including non-prescription medicine										
If yes, what medication(s) are you to	aking:				Asp	oirin		***************************************		
4. Have you ever taken Fen-Phen/Redu	rx?				Any	y Metal	s (e.g. 1	nickel, mercury, etc.)	Щ	
5. Have you ever taken Fosamax, Boniva										L.,
medications containing bisphosphon			L	4				) istent cough or throat clearing not	-	
6. Have you taken Viagra, Revati, Cial	is or Levitro	l	_	-	12, D0	you nav	ve a persi with a bri	own illness (lasting more than 3 weeks)?	П	
in the last 24 hours?				H	13. Wo			own mass (msting more than 5 weeks) !		1
7. Do you use tobacco?			=	H				int or think you may be pregnant?		
8. Do you use controlled substances?		·····	-		b) A	Are you	nursin	g?		
9. Do you have or have you had any of	100 mm	90			c) A	Are you	taking	oral contraceptives?		
	Yes N					Yes	No		Yes	No
High Blood Pressure		Heart Diseas	se	********	**********	$\sqsubseteq$		Chest Pains		
Heart Attack	1	Cardiac Pace	emake	r	,		$\vdash$	Easily Winded	Щ	_
Rheumatic Fever	= =	Heart Murm					H	Stroke		-
Swollen Ankles	H +	Angina				=	H	Hay Fever / Allergies		-
Fainting / Seizures	F	Frequently T Anemia	nea			Ħ	Ħ	Tuberculosis Radiation Therapy		$\vdash$
Low Blood Pressure	H F	Emphysema				$\Box$	Ħ	Glaucoma		-
Epilepsy / Convulsions		Cancer						Recent Weight Loss		Ē
Leukemia		Arthritis						Liver Disease		
Diabetes		Joint Replace	ement	or Imp	lant	Ц		Heart Trouble		
Kidney Diseases	Ш =	Hepatitis / Ja	undic	e		Н	$\vdash$	Respiratory Problems		
AIDS or HIV Infection		Sexually Tra	nsmitt	ed Dis	ease	$\mathbb{H}$	H	Mitral Valve Prolapse	Ц	
Thyroid Problem		Stomach Tro	ubles /	Ulcer.	\$	$\Box$		Other	L	
Patient Dental	Histo	)rv								
Name of Previous Dentist and Locati		, · y						Date of Last Exam		
Name of Previous Dentist and Local	юп		Yes	No				Date of Last Exam	Yes	No
1. Do your gums bleed while brushing	g or flossing	?			8. Do yo	ou have	e fregue	nt headaches?		
<ol><li>Are your teeth sensitive to hot or co</li></ol>					9. Do yo	ou clen	ch or g	rind your teeth?		
3. Are your teeth sensitive to sweet or					10. Do	you bit	e your l	ips or cheeks frequently?		
4. Do you feel pain to any of your teet	th?		ᆜ		11. Hav	e you e	ever had	d any difficult extractions	-	
5. Do you have any sores or lumps in			$\equiv$							Ш
6. Have you had any head, neck or ja					12. Hav	e you e	ever had	l any prolonged bleeding	-	
7. Have you ever experienced any of the	following				follo	wing e	extraction	ons?		- 님
problems in your jaw?								orthodontic treatment?		H
Clicking Pain (joint, ear, side of face) Difficulty in opening or closing			H					ures or partials?		
Difficulty in opening or closing	*************	***********	H	Ħ	15 Hav	es, aate	oj piac	ementeived oral hygiene instructions		
Difficulty in chewing			Ħ	Ħ	reac	e you e wdina t	he care	of your teeth and aums?	$\Box$	$\Box$
			-	_	16 Do	you lib	e vour	of your teeth and gums?smile?	H	H
Authorization a										
I certify that I have read and undersi	tand the ab	ove information i	to the	best of	my knowl	ledge.	The abo	ove questions have been accurately a	mswer	red.
l understand that providing incorrect diagnosis and the records of any tree	t informati atment or e	on can be danger xamination rende	ous to	my he	alth. I aut r my child	horize durino	the der	ntist to release any information inclu- cried of such Dental care to third na	iding i	the
and/or health practitioners. I author	ize and req	mest my insuranc	ce com	ipany i	o pay dire	ctly to	the der	itist or dental group insurance bene	fits	y 01 3
l certify that I have read and unders! I understand that providing incorrec diagnosis and the records of any tre and/or health practitioners. I author otherwise payable to me. I understar for payment of all services rendered	na that my on my beha	aentai insurance alf or my depende	carrie ants.	er may	pay less ti	nan the	e actua	і ын Jor services. I agree to be respo	nsible	
	455Fk.12521₩5 — \$1000A10									
×	ardian if n	ainar)						Data		_
Signature of nationt for navoutlan	aratan ij n	more		-111				Date		
Signature of patient (or parent/gu										
Signature of patient (or parent/gu Doctor's Comments										