## WELCOME

## PATIENT INFORMATION | DENTAL INSURANCE

TATILITY TIST OFFICE		~ _	A 17 A 1	1 11	114701011111				
Date		Who is responsible for this account?							
SS/HIC/Patient ID #		Relati	onship to	o Patien	t				
Patient		Insurance Co.							
Address		Group #							
City	Is patient covered by additional insurance?   Yes   No								
State Zip_		Subscriber's Name							
		Birthd	ate		SS#				
E-mail		Relati	onship to	Patien	t				
Sex M F Age		Insurance Co							
Birthdate									
☐ Married ☐ Widowed ☐ Single	☐ Minor		NMENT A		.EASE r my dependent(s), have insura	nce cover	age with		
☐ Separated ☐ Divorced ☐ Partner	ed for years		19	.,		nd assign dir			
Occupation			Na	ame of In	surance Company(ies)	ia assign an	DECKY 15		
Patient Employer/School		Dr	hanvisa n	avable to	all i	nsurance be			
Employer/School Address		respon	sible for a	all charge	s whether or not paid by insurance.				
		A ANDRESS SALES			r may use my health care information	on and may	disclose		
Employer/School Phone ()		such in	formation	to the a	bove-named Insurance Company(ies	) and their a	agents for		
Spouse's Name		the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.							
Birthdate		Healin	ant plan is	s complet	ed of one year from the date signed	below.			
			Signatu	re of Pati	ent, Parent, Guardian or Personal Re	presentative	9		
SS#		Di			David David Constitution David	I D			
Spouse's Employer		PIE	ease print	name or	Patient, Parent, Guardian or Persona	ii Hepreseni	tative		
Whom may we thank for referring you?			C	ip to Patient					
PHONE NUMBERS			03/14			7- 66			
Home ()	Work ()			Ext	Cell Phone ()				
Spouse's Work (	Best time and place to	reach vo							
IN CASE OF EMERGENCY, CONTACT (Specify		100		old.)					
Name	Programme Nave, Schoolsen on the	Relat	ionship	e consta			711		
Home Phone ()		Work	Phone (						
DESITAL LUCTORY									
DENTAL HISTORY									
Reason for today's visit	Burning sensation on tong	538	Yes	□ No	Mouth breathing	☐ Yes			
	Chew on one side of mou Cigarette, pipe, or cigar si		☐ Yes	□ No	Mouth pain, brushing Orthodontic treatment	☐ Yes			
Former Dentist	Clicking or popping jaw Dry mouth Fingernail biting Food collection between the teeth		☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes	No No	Pain around ear Periodontal treatment Sensitivity to cold	☐ Yes ☐ No			
City/State							10000		
Date of last dental visit									
Date of last dental X-rays	Foreign objects	e teetii	Yes	□ No	Sensitivity to sweets	☐ Yes			
Place a mark on "yes" or "no" to indicate if you	Grinding teeth		Yes	□ No	Sensitivity when biting	☐ Yes	□ No		
have had any of the following:  Bad breath  Yes No	Gums swollen or tender		☐ Yes	□ No	Sores or growths in your mouth	n  Yes	□ No		
Bad breath Yes No No Bleeding gums Yes No			☐ Yes	□ No	How often do you floss?				

Blisters on lips or mouth

☐ Yes ☐ No Loose teeth or broken fillings ☐ Yes ☐ No How often do you brush? \_

## HEALTH HISTORY

Physician's Name						Date of last visit			
Have you ever taken any of the names of phentermine), Pond					include co	ombinations of Ionimin, Adipex, F	astin (bra	nd	
Place a mark on "yes" or "no"									
AIDS/HIV	☐ Yes	□ No	Epilepsy	☐ Yes	□ No	Respiratory Disease	☐ Yes	□ No	
Anemia	☐ Yes	□ No	Fainting or dizziness	☐ Yes	□ No	Rheumatic Fever	☐ Yes	□ No	
Arthritis, Rheumatism	☐ Yes	□ No	Glaucoma	☐ Yes	□ No	Scarlet Fever	☐ Yes	□ No	
Artificial Heart Valves	☐ Yes	□ No	Headaches	☐ Yes	□ No	Shortness of Breath	☐ Yes	□ No	
Artificial Joints	☐ Yes	□ No	Heart Murmur	☐ Yes	□ No	Sinus Trouble	☐ Yes	□ No	
Asthma	☐ Yes	□ No	Heart Problems	☐ Yes	□ No	Skin Rash	☐ Yes	□ No	
Back Problems	☐ Yes	□ No	Hepatitis Type	Yes	□ No	Special Diet	☐ Yes	☐ No	
Bleeding abnormally, with	☐ Yes	□ No	Herpes	☐ Yes	□ No	Stroke	☐ Yes	□ No	
extractions or surgery		CIN-	High Blood Pressure	☐ Yes	□ No	Swollen Feet or Ankles	☐ Yes	□ No	
Blood Disease	Yes	□ No	Jaundice	☐ Yes	□ No	Swollen Neck Glands	☐ Yes	□ No	
Cancer	Yes	□ No	Jaw Pain	☐ Yes	□ No	Thyroid Problems	☐ Yes	□ No	
Chemical Dependency	Yes	□ No	Kidney Disease	☐ Yes	□ No	Tonsillitis	☐ Yes	□ No	
Chemotherapy Circulators Broblems	☐ Yes	□ No	Liver Disease	☐ Yes	□ No	Tuberculosis	☐ Yes	□ No	
Conganital Heart Lealans	Yes	□ No	Low Blood Pressure	☐ Yes	□ No	Tumor or growth on head or	Yes	□ No	
Congenital Heart Lesions	Yes	□ No	Mitral Valve Prolapse	☐ Yes	□ No	neck	- Van	D.N.	
Cortisone Treatments	Yes	□ No	Nervous Problems	☐ Yes	□ No	Ulcer Vanasal Diagram	Yes	□ No	
Cough, persistent or bloody	☐ Yes	□ No	Pacemaker	☐ Yes	□ No	Venereal Disease	☐ Yes	□ No	
Diabetes	Yes	□ No	Psychiatric Care	☐ Yes	□ No	Weight Loss, unexplained	Yes	□ No	
Emphysema	Yes	□ No	Radiation Treatment	☐ Yes	□ No				
Do you wear contact lenses?	☐ Yes	□ No							
Women:									
Are you pregnant? Tyes	-□ No		Due date		Are you nu	ırsing? 🗌 Yes 🔀 No			
Taking birth control pills?	Yes [	] No							
MEDICATIO List any medications you are		taking an	d the correlating	ALLE Aspirin	RGIE	∫ Local Anes	hetic		
diagnosis:	remarkation and the first	VALUE OF THE STATE			too (Cloon	ing pills) Penicillin			
					tes (Sleepi				
				Codeine		☐ Sulfa			
Pharmacy Name				☐ Iodine		Other	Other		
Phone ()				☐ Latex					
VPDATES (To b	e filled i	n at futuu	re appointments)						
				40 E Van E	No				
Has there been any change in For what conditions?	n your ne	ann since	your last dental appointmen	itr 🖂 tes 📋	No				
Are you taking any new media	cations?		If so, what?		ne de la		TRYES	Here.	
	cations r_		II so, what?						
Patient's Signature						Date			
Doctor's Signature						Date			
Has there been any change in			your last dental appointmen		No				
For what conditions?									
	natione?		If so what?					Name of the last	
Are you taking any new medic	Jauons (_		II so, what?	THE					
Patient's Signature		In T				Date			
Doctor's Signature		100				Date			