PATIENT INFORMATION

CONFIDENTIAL

	PATIENT #							
	DATE							
	HOME PHONE STATE/ ZIP/ PROV P.C							
CED	WIDOWED SEPARATED							
	WORK PHONE							
	WORK PHONESTATE/ CITY PROV							
	_ PHONE							
RELATIONSHIP TO PATIENT								
	HONE							
	ONE							
	AL INSTITUTION							
K Pł	HONE							
10								
	RELATIONSHIP TO PATIENT							
1	DATE EMPLOYED							
	STATE/ ZIP/ PROV P.C							
	UNION OR LOCAL # STATE/ ZIP/ PROV P.C							
_ 1	MAX. ANNUAL BENEFIT?							
ES,	COMPLETE THE FOLLOWING:							

(PLEASE PRINT)		DATE
NAME	BIRTHDATE	HOME PHONE
ADDRESS		STATE/ ZIP/ PROV. P.C.
E-MAIL		
	MARRIED DIVORCE	D WIDOWED SEPARATED
BUSINESS ADDRESS SPOUSE OR PARENT/GUARDIAN'S NAME EM		STATE/ ZIP/ PROV P.C WORK PHONE
IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE _		STATE/ CITY PROV
WHOM MAY WE THANK FOR REFERRING YOU?		
PERSON TO CONTACT IN CASE OF AN EMERGENCY		PHONE
RESPONSIBLE PARTY		
NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT		RELATIONSHIP
ADDRESS	HOME	PHONE
E-MAIL	CELL PI	HONE
		CIAL INSTITUTION
DRIVER'S LICENSE # BIRTHDATE	FINANC	
DRIVER'S LICENSE # BIRTHDATE EMPLOYER		
	WORK	PHONE
IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE?	YES NO	PHONE
IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE?	WORK	PHONE
IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? INSURANCE INFORMATION	YES NO	PHONE
IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE?	YES NO	RELATIONSHIP TO PATIENT
IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? INSURANCE INFORMATION NAME OF INSURED	YES NO	RELATIONSHIP TO PATIENT DATE EMPLOYED
IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? INSURANCE INFORMATION NAME OF INSURED	YES NO	RELATIONSHIP TO PATIENT DATE EMPLOYED STATE/ 7IP/
IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? INSURANCE INFORMATION NAME OF INSURED SS #/SIN NAME OF EMPLOYER SS #/SIN	YES NO WORK WORK WORK PHONE CITY	RELATIONSHIP TO PATIENT DATE EMPLOYED STATE/ PROV P.C UNION OR LOCAL #
IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? INSURANCE INFORMATION NAME OF INSURED SS #/SIN NAME OF EMPLOYER ADDRESS OF EMPLOYER	WORK YES NO WORK PHONE CITY GROUP #	RELATIONSHIP TO PATIENT DATE EMPLOYED STATE/ ZIP/ PROV P.C UNION OR LOCAL # STATE/ ZIP/
IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? INSURANCE INFORMATION NAME OF INSURED	WORK WORK WORK PHONE GROUP # CITY CITY CITY	RELATIONSHIP TO PATIENT DATE EMPLOYED STATE/ ZIP/ PROV P.C UNION OR LOCAL # STATE/ ZIP/ PROV P.C
IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? INSURANCE INFORMATION NAME OF INSURED SS #/SIN BIRTHDATE SS #/SIN NAME OF EMPLOYER ADDRESS OF EMPLOYER INSURANCE COMPANY INS. CO. ADDRESS	WORK NO NO NO NO NO NO NO N	RELATIONSHIP TO PATIENT DATE EMPLOYED STATE/ ZIP/ PROV P.C UNION OR LOCAL # STATE/ ZIP/ PROV P.C WAX. ANNUAL BENEFIT?
INSURANCE INFORMATION NAME OF INSURED	WORK YES	RELATIONSHIP TO PATIENT DATE EMPLOYED STATE/ ZIP/ PROV P.C UNION OR LOCAL # STATE/ ZIP/ PROV P.C UNION OR LOCAL # STATE/ ZIP/ PROV P.C MAX. ANNUAL BENEFIT? COMPLETE THE FOLLOWING: RELATIONSHIP
IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? INSURANCE INFORMATION NAME OF INSURED SS #/SIN BIRTHDATE SS #/SIN NAME OF EMPLOYER ADDRESS OF EMPLOYER INSURANCE COMPANY INS. CO. ADDRESS HOW MUCH IS YOUR DEDUCTIBLE? HOW MUCH DO YOU HAVE ANY ADDITIONAL INSURANCE? NAME OF INSURED	WORK YES NO WORK PHONE CITY GROUP # CITY HAVE YOU USED? YES NO IF YES	RELATIONSHIP TO PATIENT DATE EMPLOYED STATE/ ZIP/ PROV. P.C. UNION OR LOCAL # STATE/ ZIP/ PROV. P.C. MAX. ANNUAL BENEFIT? COMPLETE THE FOLLOWING: RELATIONSHIP TO PATIENT
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SIGNATURE

В	PATIENT NAME HOME ADDRESS E-MAIL BUSINESS ADDRESS				DATE OF B HOME PH CELL PH BUSINESS PH	IRTH ONE ONE			PATIENT NAME			
PATIENT MEDICAL HISTORY												
PH	IYSICIAN	OFFICE PHONE	E		DATI	E OF LAST EX	XAM					
		YES NO	8.	ARE YOU A			ANY REACTIONS TO THE FO) I OWING	?			
1.	ARE YOU UNDER MEDICAL TREATMENT NO	W?		YES NO		YES NO	YES NO					
2.	HAVE YOU EVER BEEN HOSPITALIZED FOR SURGICAL OPERATION OR SERIOUS ILLNE			ACCOUNT MANAGEMENT	G. NOVOCAINE)	6 🔲 🔲 B	ARBITURATES A	SPIRIN				
3.	ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICIN	E?		Al	INICILLIN OR OTHE			THER				
	IF YES, WHAT MEDICATION(S) ARE YOU TA	KING?			ILFA DRUGS		DDINEYE	s NO				
4	HAVE YOU EVER TAKEN FEN-PHEN/REDUX?		— 9.		HAVE A PERSISTEN S NOT ASSOCIATEI							
	DO YOU USE TOBACCO?		10		LASTING MORE TH	IAN 3 WEEKS	S)?					
6.	DO YOU USE ALCOHOL, COCAINE OR OTHE	R DRUGS?	10	A) ARE	YOU PREGNANT O	R THINK YO	U MAY BE PREGNANT?					
7.	ARE YOU WEARING CONTACT LENSES?				YOU NURSING? YOU TAKING BIRTH	H CONTROL	PILLS?					
11.		THE FOLLOWING?					COMM	ENTS				
	HEART ATTACK	HEART DISEASE CARDIAC PACEMAKER HEART MURMUR ANGINA FREQUENTLY TIRED ANEMIA EMPHYSEMA CANCER ARTHRITIS JOINT REPLACEMENT OF HEPATITIS / JAUNDICE SEXUALLY TRANSMITTE STOMACH TROUBLES /	D DISE	EASE []	CHEST PAINS EASILY WINDED STROKE HAY FEVER / AL TUBERCULOSIS RADIATION THE GLAUCOMA RECENT WEIGH LIVER DISEASE HEART TROUBL RESPIRATORY P OTHER OTHER	ERAPY T LOSS						
							SIGNATURE OF DENTIST		DATE			
		PAHE	·NI I YES	DENTAL NO	HISTORY			YES	NO			
	1. DO YOUR GUMS BLEED WHILE BRUSHING 2. ARE YOUR TEETH SENSITIVE TO HOT OR O 3. ARE YOUR TEETH SENSITIVE TO SWEET OF 4. DO YOU EEEL DAIN TO ANY OF YOUR TE	COLD LIQUIDS/FOODS? R SOUR LIQUIDS/FOODS			10. DO YOU BITE	NCH OR GRI YOUR LIPS	ND YOUR TEETH? OR CHEEKS FREQUENTL	□ Y? □				
	 DO YOU FEEL PAIN TO ANY OF YOUR T DO YOU HAVE ANY SORES OR LUMPS IN O 				IN THE PAST		DIFFICULT EXTRACTION	· 🗆				
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES? 7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING							HODONTIC WORK?					
	PROBLEMS IN YOUR JAW?	THE TOLLOWING			FOLLOWING							
	A) CLICKING? B) PAIN (JOINT, EAR, SIDE (C) DIFFICULTY IN OPENING	OR CLOSING?			CORRECT ME	ETHOD OF B	TRUCTION ON THE RUSHING YOUR TEETH? TRUCTIONS ON THE					
	D) DIFFICULTY IN CHEWING	i?			CARE OF YO		TROUTIONS ON THE					
SI	I V ANDEL VIN, VIN IN THE IN IN MANUAL COMPANY	READ AND UNDERSTAND THE ROVIDING INCORRECT INFORM				OWLEDGE, THE	ABOVE QUESTIONS HAVE BEEN	ACCURATEL	Y ANSWERED.			



PATIENT, PARENT OR GUARDIAN

DATE