Patient's Cell Phone

Patient's Email

Patient's Social Security (SS#)			_ DL#		County	100	
			Middle Init	ial SEX M	F BIRTHDATE		AGE
f Patient is a Minor, give Parent's or Guardian's			Reason for		****		
Who May We Thank for Referring You to our Offi	ice?			TODA	/'S DATE		
		RESPONSIBL	PARTY INFORMATION				
Person Who Brings in Patient							
	First				MARITAL STATUS		
RESIDENCE Street	AC DISONIC		City	180	State	Zip	
HOW LONG AT THIS ADDRESSHOM PREVIOUS ADDRESS (if less than 3 yrs.) Street		*******		0.000	State	7ie	
			RELATIONSHIP 1	O PATIENT	otate	_zip	
MPLOYER	00	CUPATION			NO. YEARS EMI	PLOYED	202
SPOUSE'S NAME Last	First		Middle		WORK PHONE		0.0000000000000000000000000000000000000
EMPLOYER	SS# _		BIRTHDATE	REL	ATIONSHIP TO PATIENT_		
EMERGENCY INFORMATION: (Person to	contact in emergency	y)	(NEAREST RELATIVE	NOT LIVING W	ITH YOU)		
Vame		••	Name		and the state of t		
Address			Address				
Phone			Phone				
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DENTAL INSURANCE INFORMATION (Prin	mary Garrier)		coverage.	Jones Hisuruno	c coverage, complet	o uno ioi uic	3000
nsured's Name nsurance Company	Phone		Name				
nsurance Co. Address			Insurance Company	3 1000	Phon	ie	
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nsured's SS# Group#_	Local	1#	Insured's Employer	Gro	Phon		
			mouleu 5 Joh	uit	oup#	_ Local#	
It is important the This information is strictly of DENTAL HISTORY	at I know about your M confidential and will no	Medical and Deni ot be released to a YES NO	al History. These facts have inyone. Thank you for taki	e a direct bearing ng the time to cor MEDICAL HIST	npletely fill out this qu	th. uestionnaire. YES	N
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DENTAL HISTORY DENTAL HISTORY HOW LONG SINCE You Have Seen A Dentist: Last COMPLETE Dental Exam, Date: Last FULL MOUTH X-RAYS, Date: Are you having PROBLEMS now? WHAT? Is your present dental health POOR? Do you wear DENTURES? (Partials or Full) Are you Would you like to know more about PERMANENT I Are you APPREHENSIVE about dental treatment? Have you had any PERIODONTAL (GUM) treatment Do your gums BLEED, or feel TENDER or IRRITERA Are your leeth SENSITIVE to hot, cold, sweets, pre Are you UNHAPPY with the APPEARANCE of your to Are you aware of GRINDING or CLENCHING your te Do you have HEADACHES, EARACHES, on ROCK PA Would you like your smile to LOOK BETTER or DIFI Do you REGULARLY use DENTAL FLOSS? Please RANK the following in the order in which they FEAR of pain # LACK of cor COST of treatment # MISSI COUSENT. In the dender specification by Diodoter to in make a thorough UNIONIES of treatment # MISSI COUSENT. In the dender specification by Diodoter to in make a thorough	Bite Wings Bite Wings I happy with them? REPLACEMENTS? Its? D2 SSURS? (circle) seeth? SHAPP FERENT? I would KEEP YOU FROM havi notern # ING work time # St. slaukon sold is patients pide to and territe subcrease and consense.	YES NO YES NO Grant Teatment: YES NO Only Teatment Teatment:	Do you have any CURR Are you under a PHYSI For what? What MEDICATIONS ar Are you PREGNANT? Do you SMOKE? FAMILY PHYSICIAN CIRCLE ANY OF THE F Heart Disease or Altac Angina Pectoris High Blood Pressure Heart Murmur Ribeumatic Fever Congenital Heart Lesio Mitra' Valve Prolapse Artificial Heart Valve Heart Rugery Artificial Joints (Hip, Kr Anemia Stroke Kidney Trouble Ulcers ARE YOU ALLERGIC T MEDICATIONS?	MEDICAL HIST ENT HEALTH PROBL CIAN'S CARE now? a you currently takin be a you be a you currently takin be a you b	ORY EMS? PHON YOU HAVE HAD, OR PRES ARC titis A (infectious) titis B (serum) Disease I Transfusion Addiction Addiction Problems) r Blisters psy or Seizures puscess hiatric Treatment coma ontherapy (Cancer, Leukemie) real Disease phils, Gonornea, etc.) EACTED ADVERSELY TO J	ESTIONATIVE. YES IN I	C C C C C C C C C C C C C C C C C C C
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