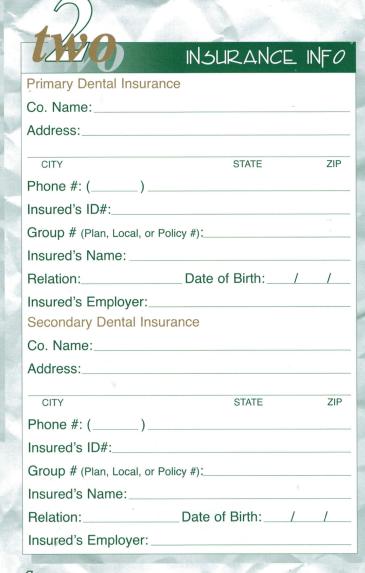
WELLCOME



ABOUT YOU

Today's Date:	1		File #:	
Patient Name:		FIRST		MI
What You Prefer To Be	Called:		🗆 Male 🖵	Female
Birthdate:/_/_	Age:_	SS#:		-
Mailing Address:				
CITY Home Phone #: (STATE		
Work Phone #: (
Cell Phone #: ()			
E-mail Address:				
Referred By:				
Employer:		Hov	w Long?	-
Employer's Address:			(27)	
CITY Occupation:		STATE		ZIP
Status: Minor Single Married Divorced Separated Widowed				
Spouse's Name:				
Do you have children?				





ACCOUNT INFO

Person ultimately responsible for account		
Name:		
Relation:		
Billing Address:		
CITY STATE ZIP		
SS #:		
Drivers License #:		
Work Phone #: ()		
☐ Credit Card - Enter card # above (if accepted)		
I hereby authorize assignment of my insurance		

Initials rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company

(if offered at this office).

IN EVENT OF EMERGENCY
Whom should we contact?
Relation:
Home Phone #: ()
Work Phone #: ()
Cell Phone #: ()
Who is your Medical Doctor?
Medical Doctor's Phone #:-()

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5	DENTAL INFORMATION		
five	Reason for today's visit: □ Exam □ Emergency □ Consultation Are you in pain? □ No □ Yes How Long? Please indicate ☑ any of the following problems: □ Discomfort, clicking or popping in jaw. □ Lost/Broken Filling(s) □ Stained teeth		
	□ Red, swollen or bleeding gums. □ Teeth grinding □ Locking Jaw □ Sensitive tooth, teeth or gums. □ Ringing in Ears □ Bad breath □ Blisters/Sores in or around the mouth. □ Broken/Chipped tooth		
	□ Other: Do you require pre-medication? □ Yes □ No □ Don't know		
	Previous Dentist: ()		
	Times a day you brush? Times a week you floss? What type of tooth brush bristles do you use? Soft Medium Hard		
	How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 1 0 (Best		

		MEDICAL HISTORY		
	you taking? 🛭 Nerve pi d Thinners 🔲 Tranquilize	Ils ☐ Pain killers (including aspirin) ☐ Muscle relaxers rs ☐ Insulin ☐ Meds for Osteoporosis		
Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) Yes No Phen-fen/Redux Yes No Procedures? Y N Cancer/Tumors Yes No Cosmetic Surgery Yes No Phen-fen/Redux Yes No Procedures? Y N Cancer/Tumors Yes No Cosmetic Surgery Yes No Phen-fen/Redux Yes No Procedures? Y N Cancer/Tumors Yes No Cosmetic Surgery Yes No Problems Yes No Cancer/Tumors Yes No Cancer/Tum				
Please list any other surgeries or medical conditions you have or ever had:				
Are you allergic to any of the following? Latex Penicillin / Amoxicillin Tetracycline Aspirin				
☐ Dental Anesthetics ☐ Foods:		Others:		
Do you use tobacco? □ No □ Yes/How used?		How much? How long?		
Please rate your general health from 1-10: Do you wear contact lenses? \(\begin{align*} \text{Yes} \equiv \text{No} \\ \text{For women:} \text{Are you taking Birth Control pills?} \(\begin{align*} \text{Yes} \equiv \text{No} \text{How many children have you had?} \equiv \text{Are you had?} \(\text{Lenses} \)				
Are you Pregnant? ☐ No ☐ Yes/How long? Are you nursing? ☐ Yes ☐ No				

