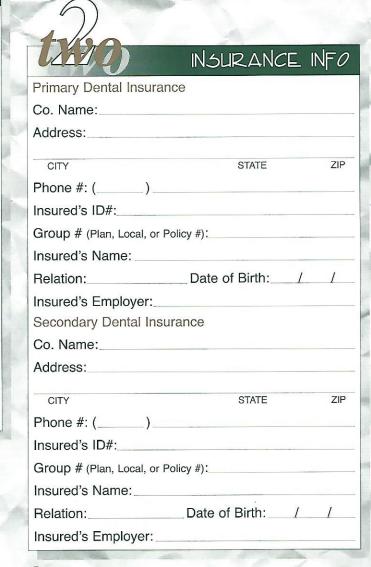
WELLCOME



Today's Date:	1		F	File #:	
Patient Name:			FIRST		- 55
LAST				MI	
What You Prefer To Be	e Called:_	_	_	_ 🗆 Male 🗅 Fema	ale
Birthdate://	Age:		_SS#:_		_
Mailing Address:					
			7		
CITY		STAT	_	ZIP	
Home Phone #: (107				
Work Phone #: ()			Ext:	_
Cell Phone #: (_)				
E-mail Address:					
Referred By:					
Employer:			How	Long?	
Employer's Address:_			10 511		
CITY		STAT	Έ	ZIP	_
Occupation:					
Status: Minor Single	e 🗆 Married	☐ Divord	ed 🗆 Se	oarated 🗆 Widow	ed
Spouse's Name:				- 148	
Do you have children?	? □ Yes □	No	How ma	any?	



4h200		
0 2 2 2 2	ACCOUNT	INF0
Person ultimately responsible	for account	
Name:		
Relation:		
Billing Address:		
CITY	STATE	ZIP
SS #:		
Drivers License #:	7.3000	
Work Phone #: () Payment method: □ Cash	□ Check	
☐ Credit Card - Enter card # above	(if accepted)	
I hereby authorize as rights and benefits d services rendered. I fully under ble for any balance not paid by (if offered at this office).	irectly to the provid stand I am solely r	der for esponsi-

Dur	IN EVENT	OF EMER	RGENCY
Whom should we	contact?		
Relation:			
Home Phone #: (_)		
Work Phone #: (_)		
Cell Phone #: ()		
Who is your Medic	cal Doctor?		
Medical Doctor's F	Phone #: ()	

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	DENTAL INF	ORMATION
Reason for today's visit: Exam Are you in pain? No Yes How Lor Please indicate any of the following pr Discomfort, clicking or popping in jaw. Red, swollen or bleeding gums. Sensitive tooth, teeth or gums. Blisters/Sores in or around the mouth.	ng?oblems: □ Lost/Broken Filling(s) □ Teeth grinding □ Ringing in Ears	☐ Stained teeth☐ Locking Jaw☐ Bad breath
☐ Other:		
Previous Dentist: Name Last Dental exam: / / L	ast Dental X-rays:)Phone#
Times a day you brush? Times a day you brush? Times a day you brush bristles do you would you rate your smile?	use? 🗆 Soft 🗀 Media	um 🗅 Hard



Initials

		MEDICAL	$_{\perp}$ μ 5 \uparrow 0 RY
Transport constant to the state of the state	you taking? ☐ Nerve pi Thinners ☐ Tranquilize	A CONTROL OF THE PROPERTY OF T	
Have you ever taken: Bis Do you have or have you Y N Heart Attack / Stroke Y N Heart Surg./Pacemaker Y N Heart Murmur Y N Rheumatic Fever Y N Mitral Valve Prolapse Y N Artificial Valves Y N Heart Disease Y N Congenital Heart Defect Y N Chest Pains Y N Scarlet Fever Y N Nervousness	Y N Thyroid Problems Y N Kidney Problems Y N Liver Problems Y N Respiratory Problems Y N Sinus Problems Y N Stomach Problems/Ulcers Y N Psychiatric Problems Y N Venereal Disease Y N Alcohol/Drug Abuse Y N Tuberculosis TB Y N Jaw Problems TMJ/TMD	seases, medical conditions or proce Y N Cancer/Tumors Y N Cos Y N Shingles Y N Xra Y N Hepatitis Y N Che Y N HIV+/AIDS/ARC Y N Ast Y N Arthritis/ Rheumatism Y N Artificial Bones/Joints Y N Emphysema Y N Leu Y N Fainting/Seizures/Epilepsy Y N Severe/Frequent Headaches Y N Hig	smetic Surgery by or Cobalt Treatment emotherapy hma ficulty Breathing betes/Hypoglycemia ukemia emia h/Low Blood Pressure eding Problems
Are you allergic to any of □ Dental Anesthetics □		☐ Penicillin / Amoxicillin ☐ Tetrac	ycline 🗆 Aspirin
Do you use tobacco? De Please rate your general For women: Are you take	No □ Yes/How used? health from 1-10: ting Birth Control pills? □	How much?	ses? Yes No

	We invite you to discuss with us any questions regarding our services. on a friendly, mutual understanding between provider and patient.	The	best	Dental	health	services	are	based
		1 121 21		100				
>	Our policy requires payment in full for all services rendered at the time of	Visit	unle	ss othe	r arran	gements	have	heen

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

♦ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

rstand it is my responsibility to inform this office of any changes to the information I have provided.

I acknowledge that I have received a copy of the Summary of Privacy Notice.

Signature

| Date / / |

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