## PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name:		-		Date of birth:	Sex		Age: _	
Home address:			(	City:	_ State:	Zip:		
Billing address (if different):	- 10-10-10-10-10-10-10-10-10-10-10-10-10-1		(	City:	State:	Zip:		
Home phone:	Cell:	E-mail:	) 2	Driver's lice	nse #:	I de la companya de l	State:	
SS #:	En	nployer/Occ	upation: <sub>-</sub>		Bus. Phone	e:		
Spouse's name & phone #:		-W-787 - 1174 W-14		Emergency phone # (o	ther than spouse):	-		
Primary dental insurance:				Group #:				
Secondary dental insurance: _	w man		<u>- 1000 (2000-91-3</u> )	Group #:				
Subscriber's name:	-			Date of birth:	SS	#:		
Name of your medical doctor:				Date of last visit to me	dical doctor:		<u> </u>	
Name of previous dentist:		-1		Date of last visit to der	ntist:			
Referred to us by:		VI.						
Are you apprehensive about de		March Machine March 1971	No	How often do yo		3	Yes	No
Have you had problems with p				How often do yo Does your jaw make		ers vou		
Do you gag easily?		S2-201/						
Do you wear dentures?				Do you clench or grir	nd your jaws frequer	ntly?		
Does food catch between your				Do your jaws ever fee	el tired?			
Do you have difficulty in chew	107000			Does your jaw get stu	ck so that you can't	open freely?		
Do you chew on only one side				Does it hurt when you	ı chew or open wid	e to take a bite? _		
Do you avoid brushing any par				Do you have earache	s or pain in front of	the ears?		
because of pain?				Do you have any jaw	symptoms or heada	ches		
Do your gums bleed easily? Do your gums bleed when you				upon awaking in	the morning?	5711		
Do your gums feel swollen or t				Does jaw pain or disc	30	2.7		
Have you ever noticed slow-he				18 15 18	ne, or other activitie		Щ.	
about your mouth?				Do you find jaw pain		34.0		
Are your teeth sensitive?					ressing?		_Ц	
Do you feel twinges of pain wh			100 mm 100	Do you take medicati	ADDITION AND INTERNAL TRAINING WINGSHIPS			
contact with:	ien your teeth come			(pain relievers, muscl				
Hot foods or liquids?				Do you have a tempo				
Cold foods or liquids?					L - T L L - : - :			
Sours?				Do you have pain in t	s?s			
Sweets?				Are you unable to ope				
Do you take fluoride suppleme	ents?			Are you aware of an u	12		-	
Are you dissatisfied with the ap	H			A CONTRACTOR OF THE PARTY OF TH				
Do you prefer to save your teet	h?			Have you had a blow				
Do you want complete dental	care?			Are you a habitual gu	m cnewer or pipe si	noker:		

MEDICAL HEALTH HISTORY: u have, or have you had, any of the following

Diabetes   Chest pain   Chest		Yes	No	*	Yes	No	
Chest pain Shorness of hearth Blood pressure problem Heart manuar Heart valve problem Heart manuar Heart valve problem Chest problem Resumatic fewer Pacemake Antificial heart valve Blood disease tamemat Blood disease tam	Heart Problems			Diabetes			
Shortness of headth				Urinate more than 6 times a day			
Blood pressure problem	Shortness of breath						
Heart mumur Heart water problems	Blood pressure problem						
Taking heaf medication Rheumatic fever Roccember Additical heart valve	Heart murmur						
Rheumatic fewer	Heart valve problem			2			
Pacemaker Additical heart valve  Blood Problems Easy bruising Frequent noseobleeds Abrormal bleeding Blood descending Blood d	Taking heart medication			Do you drink alcohol?			
Pacemaker Additical heart valve  Blood Problems Easy bruising Frequent noseobleeds Abrormal bleeding Blood descending Blood d	Rheumatic fever			If so, how much?			
Blood Problems				Do you amaka?			
Frequent nosebleeds Abnormal bleeding Blood disease (anemia) Ever require a blood transfusion?  Allergy Problems Hay fever History of head injury? Epilepsy or other stead injury? Epilepsy or debre and disease?  History of head injury? Epilepsy or debre neurological disease?  History of head injury? Epilepsy or debre neurological disease?  History of alcohol or drug abuse?  Do you have any disease, condition, or problem not list previously that you feel we should know about?  If so, please describe:  Weight gain or loss Special diet Constipation/Diarrhea Ridney or bladder problems Antholis Back or neck pain Join replacement (e.g., total lip, pins, or implants)  Frainting Spells, Seizures, or Fpilepsy Stroke(s)  Frequent or severe headaches Ihyroid problems Persistent cough or swollen glands Premedications required by physician Cacacer/lumor  Ver you allergis. ("Novocaine") Pencicillin or other antibiotics Sulfa drugs Sulfa drugs Sulfa drugs Sulfa drugs Aspirin, Acetaminophen, or Ibuprofen Codeine, Demend, or ther narcotics Reaction to metals Latex or rubber dam Other  Notes:  Patient/Parent Signature:  Patient/Parent Signature:  Patient/Parent Signature:	Artificial heart valve			A SECURITY OF THE PROPERTY OF			
Frequent nosebleeds	Blood Problems			Hepatitis, iaundice, or liver trouble		П	
Abnormal bleeding Blood disease (ameria) Ever require a blood transfusion?  Allergy Problems Hay fever Sinus problems Hay fever Sinus problems Skin rashes Taking allergy medication Ashma Intestinal Problems Ulcers Weight gain or loss Special diet Constipation/Diarrhea Kidney or bladder problems Bone or Joint Problems Bone or Joint Problems Glaucoma Do you wear contact lenses? History of alcohol or drug abuse? History of alcohol or drug abuse?  History of alcohol or drug abuse?  Fit so, please describe:  Intestinal Problems Do you have any disease, condition, or problem not list previously that you feel we should know about?  If so, please describe:  If so, please describe:  Sopical diet During the past 12 months, have you taken any of the following?  Yes Antibiotics or suffa drugs Anticoagulants (e.g., Coumadin) High blood pressure medicine Tranquilizers Insulin, Orinase, or similar drug Aspirin Digitalis or drugs for heart trouble Nitroglycerin Cortisone (steroids) Natural remedies Nonprescription drug/supplements Other  Women Yes  Are you taking contraceptives or other hormones!  Are you pursing? Have you reacted adversely, to any of the following?  Ves No Local anesthetics ("Novocaine") Penicilli nor other antibiotics Sulfa drugs Aspirin, Acetaminophen, or lbuprofen Gortisone (steroids) Natural remedies Nonprescription drug/supplements Other  Women Yes  Are you taking contraceptives or other hormones! Are you pursing? Have you reacted delivery date: Are you nursing? Have you reacted delivery date: Are you nursing? Have you reacted menopause? If so, do you have any symptoms?  Notes:  Notes:		processory .	Н	5 9/50 4/	-		
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Allergy Problems			H	HIV-positive/AIDS			
Allergy Problems			H	Glaucoma			
Hay fever Sinus problems Sinus problems Sikin rashes Taking allergy medication Asthma Intestinal Problems Ulcers Weight gain or loss Special diet Constipation/Diarrhea Kichey or bladder problems Arthritis Back or neck pain Joint replacement (e.g., total hip, pins, or implants) Fainting Spells, Seizures, or Epilepsy Strokets) Thyroid problems Intestinal Problems Arthritis Back or neck pain Joint replacement (e.g., total hip, pins, or implants) Fainting Spells, Seizures, or Epilepsy Strokets) Thyroid problems Oamset/Turnor  Vere you allergic, or have you reacted adversely, to any of the following?  Ves No  Local anesthetics ("Novocaine") Pencillin or other antibiotics Sulfa drugs Anticoagulants (e.g., Coumadin) High blood pressure medicine Tranquilizers Insulin, Orinase, or similar drug Aspirin Actain Cances/Turnor  Vere you allergic, or have you reacted adversely, to any of the following?  Ves No  Codeine, Demerol, or other narcotics Reaction to metals Lates or rubber dam Other  Notes:  Patient/Parent Signature:  History of alcohol or dug abuse?  Antibiotics or sulfa drugs  Anticoagulants (e.g., Coumadin)  High blood pressure medicine  Tranquilizers  Insulin, Orinase, or similar drug  Aspirin, Actention  Insulin, Orinase, or similar drug  Aspirin, Actention  Insulin, Orinase, or similar drug  Anticoagulants (e.g., Coumadin)  High blood pressure medicine  Tranquilizers  Insulin, Orinase, or similar drug  Anticoagulants (e.g., Coumadin)  High blood pressure medicine  Tranquilizers  Anticoag	AND CHARLEST NUMBER 1. STREET STREET CO.	-		Do you wear contact lenses?			
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Skin rashes Taking allergy medication  Asthma    Do you have any disease, condition, or problem not list previously that you feel we should know about? If so, please describe:    Do you have any disease, condition, or problem not list previously that you feel we should know about? If so, please describe:    Do you have any disease, condition, or problem not list previously that you feel we should know about? If so, please describe:    Do you have any disease, condition, or problem not list previously that you feel we should know about? If so, please describe:    Do you have any disease, condition, or problem not list previously that you feel we should know about? If so, please describe:    Do you have any disease, condition, or problem not list previously that you feel we should know about? If so, please describe:    Do you have any discoil or, or poblem not list previously that you feel we should know about? If so, please describe:    Do you have any discoil or, or poblem not list previously that you feel we should know about? If so, please describe:    Do you have any discoil or, or poblem not list previously that you feel we should know about? If so, please describe:    Do you have any feel we should know about? If so, please describe:    Do you have any should know about? If so, please describe:   Do you have any should know about? If so, please describe:   Do you have any should know about? If so, do you have any symptoms?   Do y	EL SINSE AND THE COLOR SIND AND AND AND AND AND AND AND AND AND A						
Asthma   Do you have any disease, condition, or problem not list previously that you feel we should know about? If so, please describe:  Weight gain or loss   Special diet   Constipation/Diarrhea   During the past 12 months, have you taken any of the following? Yes  Bone or Joint Problems   During the past 12 months, have you taken any of the following? Yes  Antibiotics or sulfa drugs   Antibiotics   Antibiot	Skin rashes					Ц	
Intestinal Problems							
Ulcers Weight gain or loss Special diet Constipation/Diarrhea Kidney or bladder problems Bone or Joint Problems Anthitis Back or neck pain Joint replacement Leg, total hip, pins, or implants) Fainting Spells, Seizures, or Epilepsy Strokets) Frequent or severe headaches Thyroid problems Persistent cough or swollen glands Premedications required by physician Cancer/Tumor  Cancer/Tumor Local anesthetics ("Novocaine") Penicillin or other antibiotics Sulfa drugs Barbiturates, sedatives, or sleeping pills Aspirin, Acetaminophen, or Ibuprofen Codeine, Demerol, or other narcotics Reaction to metals Latex or rubber dam Other  Notes:    Juring the past 12 months, have you taken any of the following? Yes  Antibiotics or sulfa drugs Antibiotics or sulf		_					
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Special diet Constipation/Diarrhea   Constipation/Diar	RADORAN MARK		$\exists$	If so, please describe:			
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Bone or Joint Problems	Constipation/Diarrhea		Ш	During the past 12 months, have you taken			
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Back or neck pain			Ħ			7	П
Joint replacement				# # = MV = 1 = 1   = 57 4 - 50 _ W = 24	4		H
Insulin, Orinase, or similar drug	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		$\exists$			=	H
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Thyroid problems	Suoke(s)	🗀		그래요	L	4	
Thyroid problems	Frequent or severe headaches				L		Щ
Persistent cough or swollen glands   Other    Premedications required by physician   Cancer/Tumor   Women   Yes    Are you allergic, or have you reacted adversely, to any of the following?   Yes   No    Local anesthetics ("Novocaine")   Cancer/Tumor   Are you reacted adversely, to any of the following?   Cancer/Tumor   Cancer/Tumor   Cancer/Tumor   Women   Yes    Are you alking contraceptives or other hormones?   Cancer/Tumor   Cancer/Tu	Thyroid problems				L		
Premedications required by physician					L		
Cancer/Tumor		-					
Are you taking contraceptives or other hormones?  Local anesthetics ("Novocaine")	•	25					
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Local anesthetics ("Novocaine")	and the second s				a tricker		
Penicillin or other antibiotics	to any of the following?	<u> </u>	es es	No other hormones?			
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Sulfa drugs  Barbiturates, sedatives, or sleeping pills  Aspirin, Acetaminophen, or Ibuprofen  Codeine, Demerol, or other narcotics  Reaction to metals  Latex or rubber dam  Other  Notes:  Patient/Parent Signature:				If so, expected delivery date:			
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Reaction to metals  Latex or rubber dam  Other  Notes:  Patient/Parent Signature:	있는 100 MB 및 프라이어 11 MB 보고 있는 12 MB HE THE HEAD NOTE HEAD NOT		H Beril	If so, do you have any symptoms?	(F) (100) 100		
Latex or rubber dam				H			
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