



GENERAL INFORMATION

Signature				Date	
of administering my claims.					
I authorize the practice to consult necessary or requested. I authorize					
 Ask questi 	ions and	d receive comple	ete answers reg	arding my oral health ecommended treatment	
				ny dental procedure	
options (including x-rays and pho					condition and troutmont
The dental and medical profiles staff to perform assessment and					
The decide 1 2 2 2			s Rights & Co		Mak dia ana di 1990 s
Policy Holder's Employer					
Dental Insurance Company_				Group#	
Policy Holder's Name			econdary Polic		
Policy Holder's Employer			oondary Bolis		
Claims address					
Dental Insurance Company _				Group#	
Policy Holder's Name				ID#	
			Primary Policy		
I understand that responsibility for p insurance coverage, and is due and		for Dental Service		office for myself or my dep	
Name				Other Phone	
Name		Home Phone		Other Phone	
Emergency Notification Inforn	nation				
Employer			Occupation _		
Home Phone		Work Phone_		Cell Phone_	
Spouse's Name			Birthdate _		
Employers address			Cocapation		
E-Mail Employer			Occupation		
Home Phone			Work Phone Cell Phone		
Address			Mork Dhone		
Birthdate				Martial Status	_ Male/ Female
,	3,		Patient		
Whom may we thank for refer					
How should we address you? How were you referred to our					
NAME)				
NIANAT			GENTER	THE STRUCK THE T	



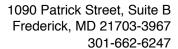


Signature

MEDICAL HISTORY

Name							
Your Primary Physician's Name Last Visit							
Are you being treated by a physician now?							
Any recent seriou	us illness? 🔲 Yes	s 🗌 No I					
Are you presently	y taking any medicat	tions? 🔲 Ye	s 🗌 No	☐ See atta	ached		
(including non-pr	escription drugs) If y	es, please list					
Any medical reas	sons that require you	ı to take an ar	tibiotic prior to	any dental tre	eatment		
☐ Yes ☐ No.	If yes what antibiotic	c are your requ	uire to take:				
	_						
Yes No		you have or ha Yes No	ive you had any	of the following Yes	•		
	cid Reflux		AIDS (HIV)			Anemia	
	tificial Heart Value	H H	Artificial Joint	Ħ	Ħ		/ Rheumatism
	sthma	T T	Blood Disorder	. 🗂	Ħ	Blood T	
	ood Transfusion		Cancer Treatm		靣		ic Surgery (Facial)
	abetes		Dizziness/ Fair			Drug Ad	• • • •
☐ ☐ Ep	oilepsy/ Seizures		Hear Loss/ Dea	af 🗌		Heart D	
П П Не	eart Murmur		Pacemaker			Heart S	urgery
☐ ☐ He	epatitis B or C		Herpes/ Fever	Blister		High Blo	ood Pressure
☐ ☐ Kie	dney Problem		Liver Disease			Mitral Va	alve Prolapse
	arcotic Allergy	닏 닏	Nervous Disord		Ц	-	tric Treatment
	espiratory Problems	片 片	Rheumatic/ Sc		H		al Allergies
	nus Trouble	Η Η	Sjogren's Synd	rome 📙		Sleep A	
	TD	片 片	Stroke	片	H	Sulfa Al	lergy
ш ш in	nyroid Disease	⊔ ⊔	Tuberculosis	Ш	Ш	Ulcers	
	Are you allergic or	have you reacte	ed adversely to a	any of the follov	ving medic	ations?	
Yes No		Yes	No		Yes	No	
–	ocal Anesthetic	님	☐ Percoo			님	Latex
	enicillin/Amoxicillin	님	Erythro	-	H	님	Valium
	trous Oxide	H	Fluorid		H	H	lodine
	ther Antibiotic Allergy edications, substances	or metals?	☐ Codeir	ie	Ш	Ш	Aspirin
raiorgy to other me	Alloutions, Substantes	or motals:					
Our office is dedica	ated to the concept tha	at all people sho	ould have the op	portunity to reta	ain their na	ıtural tee	th for a lifetime.
	res, high quality care a						
people to retain their natural teeth with optimum comfort, function, and appearance. My staff and I are dedicated to this concept and with your cooperation; we will do everything we can to help you reach your goals for dental health.							
concept and with y	our cooperation, we w	ını do everyülli	y we can to neip	you reach you	i goals ioi	Gerilai II	Caiti.

Date





DENTAL HSTORY

Complete answers to the following questions will alleparticular needs. Your answers are for our records of	•	′ •	ng the care appropriate for your				
Are you having any dental discomfort at this time?	Yes No If yes, please ex	plain					
Have you ever had any serious trouble associated v If yes, please explain	vith previous dentistry? Yes	□No					
Does dental treatment make you nervous?		•					
Date of last dental visit? Dentist Name Phone Number Phone Number							
Have you ever been treated for periodontal disease							
If yes, please explain							
Do you have or have you ever had any of the follow Yes No Biting cheek/lips Clicking/Popping Jaw Difficulty opening /closing jaw Headaches, earaches, neck pain Clenching/ Grinding Shifting in Bite Change in Bite Do you wear a night guard Fatigue/ Sleepiness during the day These are the things that are important to me about	Yes No Loose Teeth Sensitive to Hot Sensitive to Cold Sensitive to Sweets Sensitive to Biting Sensitive to Chewing Food Impaction Do you use tobacco pr		Dentures Partials Bleeding, sore gums Unpleasant taste/bad breath Burning Tongue/ Lips Swelling/ Lumps in Mouth Ortho Treatment (braces) Snoring				
What do you fear the most about dental care?							
Check one:	П						
1. My mouth is	moderately comfortable	uncomfortabl					
	2. I think the appearance of my mouth is excellent I am satisfied with the appearance of my mouth						
I am dissatisfied with the appearance of my mouth I will do anything to keep my natural teeth I want to keep my teeth, but have certain budget of time and money that I am will to spend on them.							
 I have always done the best that was recommed I have not done what dentists have recommed I rarely, go and don't care much about having I have put dentistry for myself and family low I have put dentistry on my list but it's hard to find 	mended for my dental health. ended to me. g any dental work complete. h on my priority list on my priority list. I the time						
I think my state of dental health is excellent	☐ Good ☐ Poor						
Please PRIORITIZE the following in the order in who being the highest priority Fear of Pain Lack of Concern What are some questions about dentistry and oral h	Cost of Treatmer	ntM	issing work time				
Signature	Date						