## Thank you for selecting us.

To help us meet all your healthcare needs, please fill out this form completely in ink.

If you have any questions or need assistance, please ask us and we will be happy to help.

## elcome

| Patient Information (Confidential)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Patient<br>Number                                                                          |                     |
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| Are you starting any medicational including non-prescription medicine?    leave you ever taken Farn-Phan/Radux?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        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Howey use went taken Fent-PheneRedux?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 9-08 9-15                                                                   | \ ! 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| Have you sert taken Fear-Phen/Redux?  Have you steen Vager, Revatio, Ciclis or Levitra in his last 24 hours?  Do you use controlled substances?  Do you use controlled substances?  Do you use controlled substances?  Do you shave on they you had any of the following?  Yes No  Heart Disease  Cardias Paomaker  Latar Reduct  Latar Reduct  Any or unaming and contraceptives?  Any you retaking and contraceptives?  Any you retaking and contraceptives?  Any your testing and contraceptives?  Yes No  Chast Pains  Latar Reduct  Latar Reduct With known illness (lasing not  Regount Latar Latar Reduct With known illness (lasing not  Regount Latar Latar Reduct With known illness (lasing not  Regount Latar Latar Reduct With known illness (lasing not  Regount Latar Latar Reduct With known illness (lasing not  Regount Latar Reduct With known illness (lasing not  Regount Latar Latar Regount Reduction  Reduction | ii yes, what incurcation(s) are yo                                          | ra taking:      |               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |         |         |                                                 |                          |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   | H                 |
| Latox Rubber  Cheer  Cancer mediadons containing isophosphorates?  12. Do you have a persistent cough or threat clearing not associated with a known illness disating more than 3 weeks!?  13. Women Only.  Are you taken age, Revalde, Calls or Lev/tex in the last 24 hours?  14. Women Only.  Are you mursing?  Basic mursing and contraceptives?  Are your mursing?  Basic mursing and contraceptives?  Are your mursing?  Basic mursing and contraceptives?  Are your mursing?  Basic mursing and contraceptives?  Basic mursing and contraceptive | Have you ever taken Fen-Phen/F                                              | Roduy?          | - No.         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |         |         |                                                 | PASSOCIA MARKETANA       | le a ni                                   | ickel mercury etc.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                   | ī                 |
| 2. Do you have a persistent cough or throat clearing not associated with a known illness dissing more than 3 weeks)?   13. Women only:   Are you pregnant or think you may be pregnent?   Are you retained substances?   13. Women only:   Are you pregnant or think you may be pregnent?   Are you pregnant or think you may be pregnent?   Are you pregnant or think you may be pregnent?   Are you pregnant or think you may be pregnent?   Are you pregnant or think you may be pregnent?   Are you taking oral controceptives?   Are you taking or flossing?   Are you taking oral controceptives?   Are you taking   |                                                                             |                 |               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |         |         |                                                 |                          |                                           | ionor, mercury, etc.,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                   |                   |
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| Do you have or have you had any of the following?  Yes No  Are you taking or all centracoptives?  Yes No  Are you taking or all centracoptives?  Yes No  Yes No  Yes No  Yes No  Yes No  Cordiac Pascemaker  Cardiac Pascemaker  Cardia Pascemantal Cardia | . Do you use tobacco?                                                       |                 |               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |         |         |                                                 |                          |                                           | or think you may be pregnant?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                   |                   |
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| Ab Blood Pressure   Heart Disease   Chest Pains   Gradice Pacemaker   Cardice Pacemake | ). Do you have or have you had an                                           | y of the follo  | wing?         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |         |         |                                                 |                          |                                           | I contraceptives?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                   |                   |
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| eumatic Fever   Heart Mumur   Stroke   Collen Ankles   Angina   Hay Fever/Allergias   Collen Ankles   Angina   Hay Fever/Allergias   Collen Ankles   Angina   Hay Fever/Allergias   Collen Ankles   Concer   Recent Weight Loss   Concert   Recent Weight Loss   Concert   Recent Weight Loss   Concert   Recent Weight Loss   Concert   Recent Weight Loss   Recent Weight Lo |                                                                             |                 |               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |         |         |                                                 |                          |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   |                   |
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| Inting/Seizures   Frequently Tired   Tuberculosis   Inting/Seizures   Frequently Tired   Tuberculosis   Inting/Seizures   Radiation Therapy   Inting/Seizures   Emphysema   Glaucoma   Inting/Seizures   Emphysema   Glaucoma   Inting/Seizures   Inti |                                                                             |                 |               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |         |         |                                                 |                          |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | $\Box$            | $\overline{\Box}$ |
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| Arthritis   Liver Disease   Joint Replacement or Implant   Heart Trouble   Interplacement   Interplacement   Heart Trouble   Interplacement   Interplacemen   |                                                                             |                 |               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |         |         |                                                 |                          |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   |                   |
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| Interp Diseases   Hepatitis/Jaundice   Respiratory Problems   Gos or HIV Infaction   Sexually Transmitted Disease   Mitral Valve Prolapse   Gos or HIV Infaction   Sexually Transmitted Disease   Mitral Valve Prolapse   Gother   G |                                                                             |                 |               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ment or | Imnlan  | t                                               | Ī                        |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | $\overline{\Box}$ | $\overline{\Box}$ |
| OS or HIV Infection   Sexually Transmitted Disease   Mitral Valve Prolapse   District Problem   Stomach Troubles/Ulcers   Date of Last Exam   Department of Previous Dentist and Location   Date of Last Exam   Previous Dentist and Location   Date of Last Exam   Previous Dentist and Location   Date of Last Exam   Previous Dentist and Location   Page No   Do your gums bleed while brushing or flossing?   So you have frequent headaches?   Do you for the page of Date of Last Exam   Previous Dentist to not or cold liquids/foods?   So you have frequent headaches?   Do you for the page of Date of Last Exam   Do you for Date of Cast Exam   Do you for Date of Cast Exam   Do you for Date of Cast Exam   Do you bite your lips or cheeks frequently?   Do you be dead on the past?   Do you be defined in the past?   Do you be dead on the past?   Do you were chard any prolonged bleeding   Flave you had any prolonged bleeding   Flave you had any prolonged bleeding   Flave you had any orthodontic treatment?   Do you were defined or past of Date of Past you were experienced any of the following were past of past past you for Date of Past you were experienced on the past you were experienced on the past you for Date of Past you were experienced on the past you have dead on the past you had any orthodontic treatment?   Do you were defined or Date of Past you were cheek for Date of Past you were experienced on the past you have defined any past you have any orthodontic treatment?   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| Are your teeth sensitive to sweet or sour liquids/foods?  Do you gelench or grind your teeth?  Do you have any sores or lumps in or near your mouth?  Have you have any bead, neck or jaw injuries?  Clicking  Difficulty in opening or closing  Difficulty in dewing  Difficulty in shewing  Dif |                                                                             |                 |               | The state of the s |         | Disease | 2                                               |                          |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | П                 |                   |
| atient Dental History  Ime of Previous Dentist and Location                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            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| Date of Last Exam  Yes No Do your gums bleed while brushing or flossing?  Are your teeth sensitive to hot or cold liquids/foods?  Are your teeth sensitive to sweet or sour liquids/foods?  Do you gel pain to any of your teeth?  Do you have any sores or lumps in or near your mouth?  Have you had any head, neck or jaw injuries?  Clicking  Pain (joint, ear, side of face)  Difficulty in opening or closing  Difficulty in chewing  Difficulty in experienced and understand the above information to the best of my knowledge. above questions have been accurately answered. Understand that providing incorrect or orm ychild during the period of such Dental care to third party payors and/or health cultioners. 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| Are your teeth sensitive to hot or cold liquids/foods?  Are your teeth sensitive to sweet or sour liquids/foods?  Do you feel pain to any of your teeth?  Do you have any sores or lumps in or near your mouth?  Do you have any sores or lumps in or near your mouth?  Have you had any head, neck or jaw injuries?  Have you ever experienced any of the following  problems in your jaw?  Clicking  Pain (joint, ear, side of face)  Difficulty in opening or closing  Difficulty in chewing  Difficulty in generated any of the definition to the best of my knowledge. Be above questions have been accurately answered. I understand that providing incorrect ormation can be dangerous to my health. I authorize the dentist to release any information luding the diagnosis and the records of any treatment or examination rendered to ror my child during the period of such Dental care to third party payors and/or health actitioners. I authorize and request my insurance company to pay directly  9. Do you clench or grind your teeth?  10. Do you bite your lips or cheeks frequently?  11. Have you ever had any difficult extractions in the past?  12. Have you ever had any difficult extractions?  13. Have you had any orthodontic treatment?  14. Do you wear dentures or partials?  If yes, date of placement  15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?  If yes, date of placement  15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?  If yes, date of placement  15. Have you had any orthodontic treatment?  16. Do you like your smile?  to the dentits or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. lagree to responsible for payment of all services rendered on my behalf or my dependents.  X  Signature of patient (or parent/guardian if minor)        | ramo el ritoriodo Demies ana i                                              |                 | We House      | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | No      |         | EL NE                                           | Acc. 17                  |                                           | AND STATE OF THE PARTY OF THE P | Yes               | No                |
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Do your gums bleed while brus                                            | hing or floss   | ing?          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |         |         | 8.                                              | Do you ha                | ve freq                                   | uent headaches?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   |                   |
| Do you feel pain to any of your teeth?  Do you have any sores or lumps in or near your mouth?  Have you had any head, neck or jaw injuries?  Have you had any head, neck or jaw injuries?  Have you ever experienced any of the following  Following extractions?  It have you had any orthodontic treatment?  Do you wear dentures or partials?  If yes, date of placement  If yes, date of placement  If yes, date of placement  If yes date of lacement  If yes date of l | Are your teeth sensitive to hot or cold liquids/foods?                      |                 |               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |         | 9.      | 9. Do you clench or grind your teeth?           |                          |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   |                   |
| Do you have any sores or lumps in or near your mouth?  Have you had any head, neck or jaw injuries?  Have you ever experienced any of the following  Problems in your jaw?  Clicking  Pain (joint, ear, side of face)  Difficulty in opening or closing  Difficulty in chewing  Difficulty in chewing  Difficulty in chewing  Difficulty in whead, neck or jaw injuries?  It yes, date of placement  15. Have you ever received oral hygiene instructions  regarding the care of your teeth and gums?  It have you ever received oral hygiene instructions  regarding the care of your teeth and gums?  It have you ever received oral hygiene instructions  regarding the care of your teeth and gums?  It have you ever received oral hygiene instructions  regarding the care of your teeth and gums?  It have you ever received oral hygiene instructions  regarding the care of your teeth and gums?  It have you ever received oral hygiene instructions  regarding the care of your teeth and gums?  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Do you bite your lips or cheeks frequently? |                          |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   |                   |
| Have you had any head, neck or jaw injuries?  Have you ever experienced any of the following  problems in your jaw?  Clicking  Pain (joint, ear, side of face)  Difficulty in opening or closing  Difficulty in chewing  Lithorization and Release  ertify that I have read and understand the above information to the best of my knowledge. above questions have been accurately answered. I understand that providing incorrect ormation can be dangerous to my health. I authorize the dentist to release any information control duding the diagnosis and the records of any treatment or examination rendered to orm ychild during the period of such Dental care to third party payors and/or health actitioners. I authorize and request my insurance company to pay directly  I dental insurance carrier may pay less than the actual bill for services. I agree to responsible for payment of all services rendered on my behalf or my dependents.  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Do you feel pain to any of your teeth?                                   |                 |               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |         | 11.     | Have you                                        | ever ha                  | nd any difficult extractions in the past? |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   |                   |
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X  Signature of patient (or parent/guardian if minor)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 5. Do you have any sores or lump                                            | s in or near y  | our mouth?    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |         |         | 12.                                             | Have you                 | ever ha                                   | nd any prolonged bleeding                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                   | 50000000          |
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Have you had any head, neck or jaw injuries?                             |                 |               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |         |         | following e                                     | extracti                 | ions?                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   |                   |
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