

## **Dental History**

How often do you brush?	What would you like us to do today	?	Are you	ı in dental discomfort to	day?	
Check ( / ) yes or no if you have had problems with any of the following   Y   N Bad breath	Former Dentist	Address				
Check ( / ) yes or no if you have had problems with any of the following   Y   N Bad breath	Dentist's Email	Phone				, -
Check ( / ) yes or no if you have had problems with any of the following   Y   N Bad breath	Date of last dental care	Date of				
Y   N Bad breath						
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\	□ Y □ N Bad breath □ Y □ N Bleeding gums □ Y □ N Clicking or popping jaw	☐ Y ☐ N Food collection between teeth ☐ Y ☐ N Grinding or clenching teeth ☐ Y ☐ N Loose teeth or broken fillings	OYON OYON	I Periodontal treatment I Sensitivity to cold I Sensitivity to hot	☐ Y ☐ N Sensitivity when biti	ing
Are you currently under physician care?   Y   N   If yes, describe						- >
Are you currently under physician care?   Y   N   If yes, describe	How do you feel about the appeara	ance of your teeth?				
Physician's name					dure? QY QN	
Physician's name	Other information about your den	tal health or previous treatment		in the second se		
Date of last visit						
Date of last visit		Medica	II FIIIS	lory		
If yes, describe  Are you currently under physician care?			Die .			
Have you ever had a blood transfusion?   Y   N   If yes, give approximate dates  Have you ever taken Fen-Phen/Redux?   Y   N   Nursing?   Y   N   Taking birth control pills?   Y   N    Women: Are you pregnant?   Y   N   Nursing?   Y   N   Taking birth control pills?   Y   N    Check ( ) yes or no whether you have had any of the following:    Y   N   AlDS/HIV Positive   Y   N   Cough, persistent   Y   N   Jaw pain   Y   N   Shingles    Y   N   Anaphylaxis   Y   N   Cough up blood   Y   N   Kidney disease or malfunction   Y   N   Shortness of breath malfunction   Y   N   Shingles    Y   N   Arthritis, Rheumatism   Y   N   Epilepsy   Y   N   Liver disease   Y   N   Spina Bifida      Y   N   Artificial heart valves   Y   N   Fainting   Y   N   Material allergies   (latex, wool, metal, chemicals)   Y   N   Surgical implant      Y   N   Asthma   Y   N   Glaucoma   Y   N   Mitral valve prolapse   Y   N   Swelling of feet or ankles    Y   N   Blood disease   Y   N   Heart murmur   Y   N   Rapid weight gain or loss   Abnormal bleeding   Y   N   Rapid weight gain or loss   Abnormal bleeding   Y   N   Radiation treatment   Y   N   Robert Carellers   Y   N   N   Venereal disease   Y   N   Venereal dise						
Have you ever taken Fen-Phen/Redux?	If yes, describe	8				
Have you ever taken Fen-Phen/Redux?	Are you currently under physician	care? DY DN If yes, describe				
Women: Are you pregnant?	Have you ever had a blood transfus	sion? 🗆 Y 🗆 N If yes, give approxi	nate dates	6		
Check ( ✓ ) yes or no whether you have had any of the following:  □ Y □ N AIDS/HIV Positive □ Y □ N Cough, persistent □ Y □ N Jaw pain □ Y □ N Shingles  □ Y □ N Anaphylaxis □ Y □ N Cough up blood □ Y □ N Kidney disease or malfunction □ Y □ N Skin rash  □ Y □ N Anemia □ Y □ N Diabetes □ Y □ N Liver disease □ Y □ N Spina Bifida  □ Y □ N Artificial heart valves □ Y □ N Fainting □ Y □ N Material allergies (latex, wool, metal, chemicals)  □ Y □ N Asthma □ Y □ N Glaucoma □ Y □ N Mitral valve prolapse □ Y □ N Stroke (latex, wool, metal, chemicals)  □ Y □ N Asthma □ Y □ N Headaches □ Y □ N Nervous problems  □ Y □ N Blood disease □ Y □ N Heart murmur □ Y □ N Pacemaker/ Heart surgery □ Y □ N Thyroid disease or malfunction □ Y □ N Tobacco habit □ Y □ N Chemical dependency □ Y □ N Hemophilia/ Abnormal bleeding □ Y □ N Radiation treatment □ Y □ N Tobacco habit □ Y □ N Herpes □ Y □ N Respiratory disease □ Y □ N Venereal disease	Have you ever taken Fen-Phen/Red	ux? 🗆 Y 🗅 N		•		
Y   N   AlDS/HIV Positive   Y   N   Cough, persistent   Y   N   Jaw pain   Y   N   Shingles   Y   N   Anaphylaxis   Y   N   Cough up blood   Y   N   Kidney disease or malfunction   Y   N   Skin rash   Y   N   Arthritis, Rheumatism   Y   N   Epilepsy   Y   N   Liver disease   Y   N   Skin rash   Y   N   Skin rash   Y   N   Arthritis, Rheumatism   Y   N   Fainting   Y   N   Material allergies (latex, wool, metal, chemicals)   Y   N   Stroke   Y   N   N   Stroke   Y   N   N   Stroke   Y   N   N	Women: Are you pregnant? 🛛 Y 🕻	N Nursing? Y N Taking b	irth control	pills? □Y □N		
□ Y □ N Anaphylaxis       □ Y □ N Cough up blood       □ Y □ N Kidney disease or malfunction       □ Y □ N Shortness of breath         □ Y □ N Anemia       □ Y □ N Diabetes       □ Y □ N Liver disease       □ Y □ N Spina Bifida         □ Y □ N Artificial heart valves       □ Y □ N Fainting       □ Y □ N Material allergies (latex, wool, metal, chemicals)       □ Y □ N Stroke         □ Y □ N Asthma       □ Y □ N Glaucoma       □ Y □ N Mitral valve prolapse       □ Y □ N Swelling of feet or ankles         □ Y □ N Atopic (allergy prone)       □ Y □ N Headaches       □ Y □ N Nervous problems       □ Y □ N Swelling of feet or ankles         □ Y □ N Blood disease       □ Y □ N Heart murmur       □ Y □ N Pacemaker/ Heart surgery       □ Y □ N Thyroid disease or malfunction         □ Y □ N Chemical dependency       □ Y □ N Psychiatric care       □ Y □ N Psychiatric care       □ Y □ N Tobacco habit         □ Y □ N Chemotherapy       □ Y □ N Rapid weight gain or loss Abnormal bleeding       □ Y □ N Rapid weight gain or loss Abnormal bleeding       □ Y □ N Rapid weight gain or loss Rapid weight gain or loss Abnormal bleeding       □ Y □ N Respiratory disease       □ Y □ N Volcer/Colitis         □ Y □ N Cortisone treatments       □ Y □ N High blood pressure       □ Y □ N Rheumatic/Scarlet fever       □ Y □ N Venereal disease	Check ( ✓ ) yes or no whether you h	nave had any of the following:				
□ Y □ N       Anemia       □ Y □ N       Diabetes       malfunction       □ Y □ N       Skin rash         □ Y □ N       Arthritis, Rheumatism       □ Y □ N       Epilepsy       □ Y □ N       Liver disease       □ Y □ N       Spina Bifida         □ Y □ N       Artificial heart valves       □ Y □ N       Fainting       □ Y □ N       Material allergies (latex, wool, metal, chemicals)       □ Y □ N       Stroke         □ Y □ N       Asthma       □ Y □ N       Food allergies       □ Y □ N       Mitral valve prolapse (latex, wool, metal, chemicals)       □ Y □ N       Swelling of feet or ankles         □ Y □ N       Atopic (allergy prone)       □ Y □ N       Headaches       □ Y □ N       Nervous problems       □ Y □ N       Swelling of feet or ankles         □ Y □ N       Blood disease       □ Y □ N       Heart surgery       □ Y □ N       Thy □ N       Thy □ N       Thy □ N       Thy □ N       Tobacco habit       □ Y □ N       Tobacco habit       □ Y □ N       Tobacco habit       □ Y □ N       Thy □ N       Tobacco habit       □ Y □ N       Tuberculosis       □ Y □ N       Tuberculosis       □ Y □ N       Tuberculosis       □ Y □ N       Venereal disease         □ Y □ N       Cortisone treatments       □ Y □ N       Heart surgery       □ Y □ N       Radiation treatment		☐ Y ☐ N Cough, persistent			☐ Y ☐ N Shingles	
□ Y □ N       Arthritis, Rheumatism       □ Y □ N       Epilepsy       □ Y □ N       Liver disease       □ Y □ N       Spina Bifida         □ Y □ N       Artificial heart valves       □ Y □ N       Fainting       □ Y □ N       Material allergies (latex, wool, metal, chemicals)       □ Y □ N       Stroke         □ Y □ N       Asthma       □ Y □ N       Glaucoma       □ Y □ N       Mitral valve prolapse (latex, wool, metal, chemicals)       □ Y □ N       Swelling of feet or ankles         □ Y □ N       Atopic (allergy prone)       □ Y □ N       Headaches       □ Y □ N       Nervous problems       □ Y □ N       Swelling of feet or ankles         □ Y □ N       Blood disease       □ Y □ N       Heart murmur       □ Y □ N       Pacemaker/ Heart surgery       □ Y □ N       Thyroid disease or malfunction         □ Y □ N       Cancer       □ Y □ N       Psychiatric care       □ Y □ N       Tobacco habit       □ Y □ N       Tobacco habit       □ Y □ N       Tobacco habit       □ Y □ N       Tuberculosis         □ Y □ N       Circulatory problems       □ Y □ N       Respiratory disease       □ Y □ N       V □ N       Venereal disease         □ Y □ N       Cortisone treatments       □ Y □ N       Heart surgery       □ Y □ N       Respiratory disease       □ Y □ N       □ Y □ N			DYDN	Kidney disease or		ath
□ Y □ N Artificial heart valves       □ Y □ N Fainting       □ Y □ N Material allergies (latex, wool, metal, chemicals)       □ Y □ N Stroke         □ Y □ N Artificial joints       □ Y □ N Glaucoma       □ Y □ N Mitral valve prolapse or ankles       □ Y □ N Nervous problems       □ Y □ N Nervous problems       □ Y □ N Nervous problems       □ Y □ N Thyroid disease or malfunction         □ Y □ N Blood disease       □ Y □ N Heart murmur       □ Y □ N Psychiatric care       □ Y □ N Tobacco habit         □ Y □ N Chemical dependency       □ Y □ N Hemophilia/Abnormal bleeding       □ Y □ N Rapid weight gain or loss Abnormal bleeding       □ Y □ N Respiratory disease         □ Y □ N Circulatory problems       □ Y □ N Hepes       □ Y □ N Respiratory disease         □ Y □ N High blood pressure       □ Y □ N Rheumatic/Scarlet fever			DYDN			
□ Y □ N Artificial joints       □ Y □ N Food allergies       Idates, wool, metal, chemicals       □ Y □ N Surgical implant         □ Y □ N Asthma       □ Y □ N Glaucoma       □ Y □ N Mitral valve prolapse       □ Y □ N Swelling of feet or ankles         □ Y □ N Back problems       □ Y □ N Heart murmur       □ Y □ N Nervous problems       □ Y □ N Thyroid disease or malfunction         □ Y □ N Blood disease       □ Y □ N Heart problems       □ Y □ N Psychiatric care       □ Y □ N Tobacco habit         □ Y □ N Chemical dependency       □ Y □ N Hemophilia/Abnormal bleeding       □ Y □ N Rapid weight gain or loss Abnormal bleeding       □ Y □ N Rapid weight gain or loss Radiation treatment       □ Y □ N Tuberculosis         □ Y □ N Circulatory problems       □ Y □ N Hepatitis       □ Y □ N Respiratory disease       □ Y □ N Venereal disease         □ Y □ N High blood pressure       □ Y □ N Rheumatic/Scarlet fever		A		Material allergies		
□ Y □ N Asthma       □ Y □ N Glaucoma       □ Y □ N Mitral valve prolapse       □ Y □ N Swelling of feet or ankles         □ Y □ N Atopic (allergy prone)       □ Y □ N Headaches       □ Y □ N Nervous problems       □ Y □ N Thyroid disease or malfunction         □ Y □ N Blood disease       □ Y □ N Heart murmur       □ Y □ N Pacemaker/ Heart surgery       □ Y □ N Tobacco habit         □ Y □ N Cancer       □ Y □ N Hemophilia/ Abnormal bleeding       □ Y □ N Rapid weight gain or loss Abnormal bleeding       □ Y □ N Rapid weight gain or loss Radiation treatment       □ Y □ N Tuberculosis         □ Y □ N Circulatory problems       □ Y □ N Hepatitis       □ Y □ N Respiratory disease       □ Y □ N Venereal disease         □ Y □ N High blood pressure       □ Y □ N Rheumatic/Scarlet fever	☐ Y ☐ N Artificial joints					
□ Y □ N Atopic (allergy prone)       □ Y □ N Headaches       □ Y □ N Nervous problems       □ Y □ N Pacemaker/       □	□ Y □ N Asthma	□ Y □ N Glaucoma	DYDN	State of the state		
□ Y □ N Blood disease       □ Y □ N Heart problems       □ Heart surgery       □ Y □ N Tobacco habit         □ Y □ N Cancer       □ Y □ N Hemophilia/ Abnormal bleeding       □ Y □ N Rapid weight gain or loss Abnormal bleeding       □ Y □ N Rapid weight gain or loss Abnormal bleeding       □ Y □ N Rapid weight gain or loss Radiation treatment       □ Y □ N Tuberculosis         □ Y □ N Circulatory problems       □ Y □ N Herpes       □ Y □ N Respiratory disease       □ Y □ N Ulcer/Colitis         □ Y □ N Rheumatic/Scarlet fever       □ Y □ N Rheumatic/Scarlet fever	☐ Y ☐ N Atopic (allergy prone)					
□ Y □ N Cancer       □ Describe       □ Y □ N Psychiatric care         □ Y □ N Chemical dependency       □ Y □ N Hemophilia/ Abnormal bleeding       □ Y □ N Rapid weight gain or loss         □ Y □ N Chemotherapy       □ Y □ N Herpes       □ Y □ N Radiation treatment         □ Y □ N Tobacco habit       □ Y □ N Tonsillitis         □ Y □ N Radiation treatment       □ Y □ N Ulcer/Colitis         □ Y □ N Respiratory disease       □ Y □ N Venereal disease         □ Y □ N Rheumatic/Scarlet fever			YON			II.
□ Y □ N Chemical dependency       □ Y □ N Hemophilia/ Abnormal bleeding       □ Y □ N Rapid weight gain or loss       □ Y □ N Tonsillitis         □ Y □ N Chemotherapy       □ Y □ N Herpes       □ Y □ N Radiation treatment       □ Y □ N Ulcer/Colitis         □ Y □ N Respiratory disease       □ Y □ N Respiratory disease         □ Y □ N Respiratory disease       □ Y □ N Venereal disease			DVDN		☐ Y ☐ N Tobacco habit	
□ Y □ N Chemotherapy       □ Y □ N Circulatory problems       □ Y □ N Herpes       □ Y □ N Radiation treatment       □ Y □ N Ulcer/Colitis         □ Y □ N Cortisone treatments       □ Y □ N High blood pressure       □ Y □ N Respiratory disease       □ Y □ N Venereal disease		☐ Y ☐ N Hemophilia/			☐ Y ☐ N Tonsillitis	. *
□ Y □ N Circulatory problems □ Y □ N Hepatitis □ Y □ N High blood pressure □ Y □ N Respiratory disease □ Y □ N Venereal disease						
□ Y □ N Cortisone treatments □ Y □ N Hepatitis □ Y □ N Rheumatic/Scarlet fever □ Y □ N Venereal disease	□ Y □ N Circulatory problems					
	☐ Y ☐ N Cortisone treatments				☐ Y ☐ N Venereal disease	
Does parchetaire at again, it yes, its can.	Is natient currently taking any med		Does nati	ent have drug allergiës? I	f ves list all:	
	to particular controller taking any met	deach in yes, not un.	,	erreriuve ar ag uner gies! I	i yes, not un.	
	and the same of th					Y A
			Harris			A THE IS



## Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_\_\_\_\_\_\_ Date \_\_\_\_\_

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you.

We look forward to working with you in maintaining your dental health.



## Patient Information

Name	3	No.	14/7/	Soc. Sec. #				
Last Name Address	First Name		Initial					
City		Zin		Home Phone				
Cell Phone	Email	Maria de la companya	*			This art right	*	
Sex DM DF AgeBirthdate _			☐ Married	☐ Widowed	☐ Separated	☐ Divorced		
Patient Employed by							. 3	
Business Address	The sales of	Ві	usiness Ph	one			3 -	
Business Email								
Whom may we thank for referring you?								
Notify in case of emergency	H	ome Phone		-				
Cell Phone	W	ork Phone	-					
Email			1 4	818	- 3	. 4		6.4
	Prin	nary I	nsur	ance				
Person Responsible for Account	Loot Nove			n:	( ) )		A	
Polation to Patient	Last Name	data	4		t Name		Initial	
Relation to PatientAddress (if different from patient)	BIFC			Lomo Dhono				
City							7	
Cell Phone								
Person Responsible Employed by				Occupation		· halam		
Business Address								1
Business Email				ousiness i non	*			
Insurance Company				Phone *	e e	Mary Control	1	6 N
Insurance Email		*	4	and the same		and the same		dita
Contract # G				Euloceilor #	17			
	тоир *			subscriber # _				
Name of other dependents under this plan_	1		-84			Control of the Contro		
Is patient covered by additional insurance?		ional	Insu	rance				
Subscriber Name	Relat	ion to Patien	t		_ Birthdate			
Address (if different from patient)				Soc. Sec. #				
City	State	_ Zip		Home Phone_				
Cell Phone			1	Email				
Subscriber Employed by	1. 1. 1. 1. 1.		I	Business Phone	<u> </u>			
Business Email			Car .			. 4		6 .
Insurance Company			4	Phone			a	
Insurance Email			A way in	Hone				
				1 1				
	roup #			Subscriber #	0			
Name of other dependents under this plan_		-						