Thank You for Selecting Our Dental Team

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.

SS#/SIN Birthdate Hithdate Standings City Premail Company City Premail Company City Premail Company City Premail City City Premail City City Premail City Cit	Patient Number			
Address City Pst. Email Cc Check Appropriate Box: Minor Single Married Separated D St. Student, Name of School/College City Pst. Patient or Parent/Guardian's Employer Ww. Patient or Parent/Guardian's Employer Ww. Spouse or Parent/Guardian's Name Employer Ww. Whom May We Thank for Referring You? Person to Contact in Case of Emergency Pst. Responsible Party Responsible for this Account to Address Hot. Address Birthdate Financial Inst. Employer Work Phone Ss. Is this Person Currently a Patient in our Office? Yes No For your convenience, we offer the following methods of payment. Please check the option you prefer. Part Work Phone Ss. Instarance Information Responsible of the St. S	Date			
Address	Home Phone			
Check Appropriate Box: Minor Single Married Separated. D State	tate/ rov.	Zip/ P.C.		
If Student, Name of School/College	ell Phone			
If Student, Name of School/College	Divorced	Widowed		
Business Address City Str. Spouse or Parent/Guardian's Name Employer Ww. Whom May We Thank for Referring You? Person to Contact in Case of Emergency Name of Person Responsible for this Account to Address Headings and Address Headings and Address Headings and Address Headings and Address Nor Property Cash Person Currently a Patient in our Office? Yes No For your convenience, we offer the following methods of payment. Please check the option you prefer. Pa Cash Personal Check Credit Card VISA MasterCard I wish to Insurance Information Name of Insured SE#/SIN Dawnee of Employer Union or Local # Work Phone Situations Co. Address City Property Property City Propert	tate/ rov	Full Time Part Tim		
Business Address City Propose or Parent/Guardian's Name Employer Whom May We Thank for Referring You? Person to Contact in Case of Emergency Propose of Person Responsible Party Name of Person Responsible for this Account to Address History Propose States and Person Responsible for this Account to Address History Propose States Propose Financial Insurance Insuranc	Vork Phone			
Whom May We Thank for Referring You? Person to Contact in Case of Emergency Responsible Party Name of Person Responsible for this Account Address Email Driver's License # Birthdate Financial Insurance? Yes No For your convenience, we offer the following methods of payment. Please check the option you prefer. Party of the personal Check Credit Card VISA MasterCard I wish to Insurance Information Real Name of Insured Birthdate SS#/SIN Da Da Group # Polymation Group # Polymatics City Free Property of the Much Is Your Deductible? How Much Have You Used? Name of Insured Do You Have Any Additional Insurance? Yes No If Yes, Complete the Following Real Insurance City Free Property On The	tate/ rov	Zip/ P.C.		
Person to Contact in Case of Emergency Responsible Party Name of Person Responsible for this Account Address Email Ce Driver's License # Birthdate Financial Ins Employer Work Phone SS Is this Person Currently a Patient in our Office? Yes No For your convenience, we offer the following methods of payment. Please check the option you prefer. Pa Cash Personal Check Credit Card VISA MasterCard I wish to Insurance Information Re Birthdate SS#/SIN Da Name of Employer Union or Local # Wo Sin Employer Address City Pro How Much is Your Deductible? How Much Have You Used? Ma Do You Have Any Additional Insurance? Yes No If Yes, Complete the Following Name of Employer Union or Local # Se Employer Address City Pro Do You Have Any Additional Insurance? Yes No If Yes, Complete the Following Name of Employer Union or Local # Se Employer Address City Pro Do You Have Any Additional Insurance? Yes No If Yes, Complete the Following Name of Employer Union or Local # Se Employer Address City Pro Do You Have Any Additional Insurance? Union or Local # Se Employer Address City Pro Emplo	Vork Phone			
Responsible Party Name of Person Responsible for this Account Address				
Re Name of Person Responsible for this Account	hone			
Name of Person Responsible for this Account to Address Hair Address Hair Address Hair Birthdate Financial Interpolyer Work Phone SS Is this Person Currently a Patient in our Office? Yes No For your convenience, we offer the following methods of payment. Please check the option you prefer. Pa Cash Personal Check Credit Card VISA MasterCard I wish to Insurance Information Rea Re Birthdate SS#/SIN Da Name of Employer Union or Local # Work Phone SS Insurance Company Group # Pointsurance Company Group # Pointsurance Company How Much is Your Deductible? How Much Have You Used? Ma Do You Have Any Additional Insurance? Yes No If Yes, Complete the Following Name of Employer SS#/SIN Da Wane of Employer Union or Local # SS#/SIN Da Name of Employer Union or Local # Work States SS#/SIN Da Wane of Employer Union or Local # Work States SS#/SIN Da Wane of Employer Union or Local # Work States SS#/SIN Da Wane of Employer Union or Local # Work States SS#/SIN Da Wane of Employer Union or Local # Work States Stat				
Address	elationship Patient			
Email				
Driver's License # Birthdate Financial Instance Work Phone SS Is this Person Currently a Patient in our Office? Yes No For your convenience, we offer the following methods of payment. Please check the option you prefer. Pa				
Employer Work Phone SS. Is this Person Currently a Patient in our Office?				
Is this Person Currently a Patient in our Office? Yes No For your convenience, we offer the following methods of payment. Please check the option you prefer. Pa Cash Personal Check Credit Card VISA MasterCard I wish to Insurance Information Re Name of Insured Birthdate SS#/SIN Da Name of Employer Union or Local # Wo Insurance Company Group # Pol Ins. Co. Address City Pre How Much is Your Deductible? How Much Have You Used? Name of Insured Do You Have Any Additional Insurance? Yes No If Yes, Complete the Following Name of Employer Union or Local # Wo Sta City Re	S#/SIN			
Name of Insured	elationship			
Name of Employer	Patient			
Employer Address City Sta Pre Insurance Company Group # Pol Ins. Co. Address City Sta Pre How Much is Your Deductible? How Much Have You Used? Ma Do You Have Any Additional Insurance? Yes No If Yes, Complete the Following Name of Insured SS#/SIN Da Name of Employer Union or Local # Wo Sta Employer Address City Pre	ate Employed_			
Employer Address City Pro Insurance Company Group # Pol Sta Ins. Co. Address City Pro How Much is Your Deductible? How Much Have You Used? Ma Do You Have Any Additional Insurance? Yes No If Yes, Complete the Following Name of Insured Rel Birthdate SS#/SIN Da Name of Employer Union or Local # Wo Sta Employer Address City Pro	ork Phone			
Ins. Co. Address City Sta Pro How Much is Your Deductible? How Much Have You Used? Ma Do You Have Any Additional Insurance? Yes No If Yes, Complete the Following Rel to	rov.	Zip/ P.C.		
Ins. Co. Address City Pro How Much is Your Deductible? How Much Have You Used? Ma Do You Have Any Additional Insurance? Yes No If Yes, Complete the Following Rel to Birthdate SS#/SIN Da Name of Employer Union or Local # Wo Sta Employer Address City Pro		7:/		
Do You Have Any Additional Insurance? Yes No If Yes, Complete the Following Rel to Birthdate SS#/SIN Da Name of Employer Union or Local # Wo Sta Employer Address City Pro	rov.	Zip/ P.C.		
Retail	ax. Annual Ber	nefit		
Name of Insured		THE REAL PROPERTY.		
Name of Employer	elationship Patient			
Employer Address City Sta	ate Employed_			
Employer Address City Pro	ork Phone	7141		
Insurance Company Group # Poi	rov.	Zip/ P.C.		
	olicy/ID#	7111		
	rov.	Zip/ P.C.		
How Much is Your Deductible? How Much Have You Used? Ma	lax. Annual Ber	nefit		

Physician		- 10		-	Office Phone	2	H		Date of Last Exam_		
				Yes	No					Yes	N
1. Are you under medical treatme	ent now?					10. Are you w	/ets	aring co	ontact lenses?		
Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?			10. Are you wearing contact lenses? 11. Are you allergic to or have you had any reaction				or have you had any reactions to the fo	llowing?			
If yes, please explain							01	any o	(e.g. Novocain) ther Antibiotics		
2. Assessment the construction of the construc					Barbiturat				Ĭ	t	
Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking?					Sedatives Iodine						
					Aspirin						
								ickel, mercury, etc.)			
4. Have you ever taken Fen-Phen/Redux?					Latex Rubber Other						
Have you ever taken Fosamax, cancer medications containing			ny						sistent cough or throat clearing not nown illness (lasting more than 3 week	6)7	-
6. Have you taken Viagra, Revatio	o, Cialis or L	evitra			-	13. Women O			The state of the s		
in the last 24 hours?								A 11-	or think you may be pregnant?		
7. Do you use tobacco?				H		Are you nu		24			
3. Do you use controlled substan				Ш.	4	Are you ta	iki	ing ora	l contraceptives?		L
9. Do you have or have you had :											
High Blood Pressure	Yes	No	The Die			Yes		No		Yes	No
Heart Attack			Heart Disea Cardiac Pa		atomic .			H	Chest Pains		-
Rheumatic Fever	H	To a	Heart Mun		акег	H		i i	Easily Winded Stroke	H	
Swollen Ankles	5	i i		mu		H		8		H	
Fainting/Seizures		1	Angina Frequently	Time		H		ŏ	Hay Fever/Allergies Tuberculosis		
Asthma		ī	Anemia	THE	AL .			ŏ.			
ow Blood Pressure								Ĭ.	Radiation Therapy		
		6	Emphysem	ıa		H		-	Glaucoma	i	
pilepsy/Convulsions eukemia		6	Cancer			H H		5	Recent Weight Loss		
	A	H	Arthritis		The state of the s			ä	Liver Disease	ä	
		F			ent or Implant				Heart Trouble	H	
Kidney Diseases	Ē		Hepatitis/Ja	aund	ice				Respiratory Problems	ĕ	
Kidney Diseases AIDS or HIV Infection			Hepatitis/Ja Sexually Tr	aund	ice nitted Disease				Respiratory Problems Mitral Valve Prolapse	1000	
Kidney Diseases AIDS or HIV Infection Thyroid Problem	L Hi		Hepatitis/Ja Sexually Tr Stomach Tr	aund	ice nitted Disease				Respiratory Problems		PPP
Ridney Diseases AIDS or HIV Infection Chyroid Problem Patient Denta	al His		Hepatitis/Ja Sexually Tr Stomach Tr	aund	ice nitted Disease				Respiratory Problems Mitral Valve Prolapse		
Diabetes Kidney Diseases AIDS or HIV Infection Thyroid Problem Patient Denta Name of Previous Dentist Previous Dentists' Location	al His		Hepatitis/Ja Sexually Tr Stomach Tr	aund	ice nitted Disease				Respiratory Problems Mitral Valve Prolapse Other		
Kidney Diseases AIDS or HIV Infection Thyroid Problem Patient Denta Name of Previous Dentist	al His		Hepatitis/Ja Sexually Tr Stomach Tr	aund ransr roub	nitted Disease les/Ulcers				Respiratory Problems Mitral Valve Prolapse Other Date of Last Exam		Z
Kidney Diseases AIDS or HIV Infection Thyroid Problem Patient Denta Name of Previous Dentist		stor	Hepatitis/Ja Sexually Tr Stomach Tr	aund ransr roub	itice mitted Disease les/Ulcers				Respiratory Problems Mitral Valve Prolapse Other Date of Last Exam		
Kidney Diseases AIDS or HIV Infection Thyroid Problem Patient Denta Name of Previous Dentist Previous Dentists Location Do your gums bleed while brus	shing or flos	stor	Hepatitis/Is Sexually Ir Stomach Tr	aund ransr roub	nitted Disease les/Ulcers	8. Do you hav	ve	freque	Respiratory Problems Mitral Valve Prolapse Other Date of Last Exam Date of Last Cleaning		
Ridney Diseases AIDS or HIV Infection Thyroid Problem Patient Denta Name of Previous Dentist Previous Dentist's Location Do your gums bleed while brus L Are your teeth sensitive to hot	shing or flos	stor	Hepatitis/Ja Sexually Tr Stomach Tr	aund ransr roub	nitted Disease les/Ulcers	8. Do you hav	ve	freque	Respiratory Problems Mitral Valve Prolapse Other Date of Last Exam Date of Last Cleaning		
Ridney Diseases AIDS or HIV Infection Thyroid Problem Patient Denta Name of Previous Dentist Previous Dentist's Location Do your gums bleed while brus Are your teeth sensitive to hot. Are your teeth sensitive to sween	shing or flos or cold liqui et or sour liq	stor	Hepatitis/Ja Sexually Tr Stomach Tr	aund ransr roub	nitted Disease les/Ulcers	8. Do you hav 9. Do you cle 10. Do you bit	ve	freque ch or g	Respiratory Problems Mitral Valve Prolapse Other Date of Last Exam Date of Last Cleaning ent headaches? rind your teeth?		
Ridney Diseases AIDS or HIV Infection Thyroid Problem Patient Denta Name of Previous Dentist Previous Dentist's Location Do your gums bleed while brus Are your teeth sensitive to hot Are your teeth sensitive to swee Do you feel pain to any of your	shing or floss or cold liqui et or sour liq r teeth?	stor	Hepatitis/Ja Sexually Tr Stomach Tr	aund ransr roub	nitted Disease les/Ulcers	8. Do you hav 9. Do you cle 10. Do you bit 11. Have you e	ve	freque ch or g your li	Respiratory Problems Mitral Valve Prolapse Other Date of Last Exam Date of Last Cleaning ent headaches? rind your teeth? ps or cheeks frequently?		
Ridney Diseases AIDS or HIV Infection Thyroid Problem Patient Denta Name of Previous Dentist Previous Dentist's Location Do your gums bleed while brus Are your teeth sensitive to hot Are your teeth sensitive to sweet Do you feel pain to any of your Do you have any sores or lump	shing or floss or cold liqui et or sour liq r teeth? os in or near	stor	Hepatitis/Ja Sexually Tr Stomach Tr	aund ransr roub	nitted Disease les/Ulcers	8. Do you hav 9. Do you cle 10. Do you bit 11. Have you e	ve ene ev	freque ch or g your li er had	Respiratory Problems Mitral Valve Prolapse Other Date of Last Exam Date of Last Cleaning ent headaches? rind your teeth? ps or cheeks frequently? any difficult extractions in the past? any prolonged bleeding		
Ridney Diseases AIDS or HIV Infection Thyroid Problem Patient Denta Name of Previous Dentist Previous Dentist's Location Do your gums bleed while brus Are your teeth sensitive to hot Are your teeth sensitive to sweet Do you feel pain to any of your Do you have any sores or lump Have you had any head, neck of	shing or floss or cold liqui et or sour liq r teeth? os in or near or jaw injurie	stor	Hepatitis/Ja Sexually Tr Stomach Tr	aund ransr roub	nitted Disease les/Ulcers	8. Do you have 9. Do you cle 10. Do you bit 11. Have you e following e	ve ene eve	freque ch or g your liper had er had traction	Respiratory Problems Mitral Valve Prolapse Other Date of Last Exam Date of Last Cleaning ent headaches? rind your teeth? ps or cheeks frequently? any difficult extractions in the past? any prolonged bleeding ns?		
Ridney Diseases AIDS or HIV Infection Thyroid Problem Patient Denta Name of Previous Dentist Previous Dentist's Location Do your gums bleed while brus Are your teeth sensitive to hot Are your teeth sensitive to sweeth Do you feel pain to any of your Do you have any sores or lump Have you had any head, neck of Have you ever experienced any	shing or floss or cold liqui et or sour liq r teeth? os in or near or jaw injurie	stor	Hepatitis/Ja Sexually Tr Stomach Tr	aund ransr roub	nitted Disease les/Ulcers	8. Do you have 9. Do you cle 10. Do you bit 11. Have you e following e 13. Have you	ve ene eve ex ha	freque ch or g your li er had traction d any o	Respiratory Problems Mitral Valve Prolapse Other Date of Last Exam Date of Last Cleaning ent headaches? rind your teeth? ps or cheeks frequently? any difficult extractions in the past? any prolonged bleeding ns? orthodontic treatment?		
Ridney Diseases AIDS or HIV Infection Thyroid Problem Patient Denta Name of Previous Dentist Previous Dentist's Location Do your gums bleed while brus Are your teeth sensitive to hot Are your teeth sensitive to sweet Do you feel pain to any of your Do you have any sores or lump Have you had any head, neck of	shing or floss or cold liqui et or sour liq r teeth? os in or near or jaw injurie	stor	Hepatitis/Ja Sexually Tr Stomach Tr	aund ransr roub	nitted Disease les/Ulcers	8. Do you have 9. Do you cle 10. Do you bit 11. Have you e following e 13. Have you h 14. Do you we	ve eve eve ex ha	freque ch or g your li er had er had traction d any of	Respiratory Problems Mitral Valve Prolapse Other Date of Last Exam Date of Last Cleaning ent headaches? rind your teeth? ps or cheeks frequently? any difficult extractions in the past? any prolonged bleeding ns? orthodontic treatment? res or partials?		
Ridney Diseases AIDS or HIV Infection Thyroid Problem Patient Denta Name of Previous Dentist Previous Dentist's Location Do your gums bleed while brust. Are your teeth sensitive to hot. Are your teeth sensitive to sweet. Do you feel pain to any of your. Do you have any sores or lump. Have you had any head, neck of Have you ever experienced any problems in your jaw? Clicking	shing or flost or cold liqui et or sour liq r teeth? ss in or near or jaw injurie of the follow	stor	Hepatitis/Ja Sexually Tr Stomach Tr	aund ransr roub	nitted Disease les/Ulcers	8. Do you have 9. Do you cle 10. Do you bit 11. Have you e following e 13. Have you have 14. Do you wee 1f yes, date	ve eve eve ha	freque ch or g your li er had traction d any of dentur	Respiratory Problems Mitral Valve Prolapse Other Date of Last Exam Date of Last Cleaning ent headaches? rind your teeth? ps or cheeks frequently? any difficult extractions in the past? any prolonged bleeding ns? orthodontic treatment? res or partials? ement		
Ridney Diseases AIDS or HIV Infection Thyroid Problem Patient Denta Name of Previous Dentist Previous Dentist's Location Do your gums bleed while brust. Are your teeth sensitive to hot. Are your teeth sensitive to sweet. Do you feel pain to any of your to be you have any sores or lump. Have you had any head, neck of Have you ever experienced any problems in your jaw? Clicking Pain (joint, ear, side of face	shing or flost or cold liqui et or sour liq r teeth? os in or near or jaw injurie of the follow	stor	Hepatitis/Ja Sexually Tr Stomach Tr	aund ransr roub	No	8. Do you hav 9. Do you cle 10. Do you bit 11. Have you e following e 13. Have you h 14. Do you we If yes, date 15. Have you e	ve energe excha	freque ch or g your li er had traction d any of denture of place	Respiratory Problems Mitral Valve Prolapse Other Date of Last Exam Date of Last Cleaning ent headaches? rind your teeth? ps or cheeks frequently? any difficult extractions in the past? any prolonged bleeding ns? orthodontic treatment? res or partials? ement ived oral hygiene instructions		
Cidney Diseases AIDS or HIV Infection Chyroid Problem Patient Denta Name of Previous Dentist Previous Dentist's Location Do your gums bleed while brus Are your teeth sensitive to hot. Are your teeth sensitive to swee Do you feel pain to any of your Do you have any sores or lump Have you had any head, neck of Have you ever experienced any problems in your jaw? Clicking Pain (joint, ear, side of fac Difficulty in opening or cl	shing or flost or cold liqui et or sour liq r teeth? os in or near or jaw injurie of the follow	stor	Hepatitis/Ja Sexually Tr Stomach Tr	aund ransr roub	No	8. Do you have 9. Do you cle 10. Do you bit 11. Have you e following e 13. Have you have 14. Do you wen 15 yes, date 15. Have you e regarding to	ve eve ex ha ear	freque ch or g your liper had traction d any of dentu- of place er recei	Respiratory Problems Mitral Valve Prolapse Other Date of Last Exam Date of Last Cleaning ent headaches? rind your teeth? ps or cheeks frequently? any difficult extractions in the past? any prolonged bleeding ns? orthodontic treatment? res or partials? ement ived oral hygiene instructions of your teeth and gums?		
Ridney Diseases AIDS or HIV Infection Thyroid Problem Patient Dento Name of Previous Dentist Previous Dentist's Location Do your gums bleed while brust. Are your teeth sensitive to hot. Are your teeth sensitive to sweet. Do you feel pain to any of your. Do you have any sores or lump. Have you had any head, neck of Have you ever experienced any problems in your jaw? Clicking Pain (joint, ear, side of fact Difficulty in opening or clicking)	shing or flost or cold liqui et or sour liq r teeth? os in or near or jaw injurie of the follow	stor	Hepatitis/Ja Sexually Tr Stomach Tr	aund ransr roub	No	8. Do you hav 9. Do you cle 10. Do you bit 11. Have you e following e 13. Have you h 14. Do you we If yes, date 15. Have you e	ve eve ex ha ear	freque ch or g your liper had traction d any of dentu- of place er recei	Respiratory Problems Mitral Valve Prolapse Other Date of Last Exam Date of Last Cleaning ent headaches? rind your teeth? ps or cheeks frequently? any difficult extractions in the past? any prolonged bleeding ns? orthodontic treatment? res or partials? ement ived oral hygiene instructions of your teeth and gums?		
Cidney Diseases AIDS or HIV Infection Chyroid Problem Patient Denta Name of Previous Dentist Previous Dentist's Location Do your gums bleed while brus Are your teeth sensitive to hot Are your teeth sensitive to swee Do you feel pain to any of your Do you have any sores or lump Have you had any head, neck of Have you ever experienced any problems in your jaw? Clicking Pain (joint, ear, side of fac Difficulty in opening or cl Difficulty in chewing	shing or flost or cold liqui et or sour lic r teeth? os in or near or jaw injurie of the follow (ce)	stor sing? ds/foods? quids/foods your mon	Hepatitis/Ja Sexually Tr Stomach Tr	Yes	No	8. Do you have 9. Do you cle 10. Do you bit 11. Have you e following e 13. Have you he 14. Do you we figes, date 15. Have you e regarding to 16. Do you like	ve eve eve ha e c	freque ch or g your liper had traction d any of dentu- of place er receive care of	Respiratory Problems Mitral Valve Prolapse Other Date of Last Exam Date of Last Cleaning ent headaches? rind your teeth? ps or cheeks frequently? any difficult extractions in the past? any prolonged bleeding ns? orthodontic treatment? res or partials? ement ived oral hygiene instructions of your teeth and gums? mile?	Yes	
Ridney Diseases AIDS or HIV Infection Thyroid Problem Patient Denta Name of Previous Dentist Previous Dentist's Location Do your gums bleed while brust. Are your teeth sensitive to hot. Are your teeth sensitive to sweet. Do you feel pain to any of your to Do you have any sores or lump. Have you had any head, neck of Have you ever experienced any problems in your jaw? Clicking Pain (joint, ear, side of fact Difficulty in opening or cliptificulty in opening or cliptificulty in chewing the certify that I have read and understand the problems in your guestions have reviding incorrect information can or release any information including	shing or flost or cold liquitet or sour liquitet or sour liquitet or sour liquitet or near or jaw injurier of the following losing	sing? ds/foods?quids/food your mones? wing we informately answs to my he is and the	Hepatitis/Ja Sexually Tr Stomach Tr Stomach Tr Stomach Tr the stomach Tr t	Yes tof r	No Sample of the control of the cont	8. Do you have 9. Do you cle 10. Do you bit 11. Have you e following e 13. Have you have 14. Do you we regarding to 16. Do you like to me 1 bill for services, behalf or my dep	vee eevevee haard di	freque ch or g your liper had traction d any of dentu- of place er recei e care o your sr irectly to inderstanagree to	Respiratory Problems Mitral Valve Prolapse Other Date of Last Exam Date of Last Cleaning ent headaches? rind your teeth? ps or cheeks frequently? any difficult extractions in the past? any prolonged bleeding ns? orthodontic treatment? res or partials? ement ived oral hygiene instructions of your teeth and gums?	Yes	N C C C C C C C C C C C C C C C C C C C
Ridney Diseases AIDS or HIV Infection Thyroid Problem Patient Denta Name of Previous Dentist Previous Dentist's Location 1. Do your gums bleed while brus 2. Are your teeth sensitive to hot. 3. Are your teeth sensitive to sweet 4. Do you feel pain to any of your 5. Do you have any sores or lump 6. Have you had any head, neck of 7. Have you ever experienced any problems in your jaw? Clicking Pain (joint, ear, side of fac Difficulty in opening or cl	shing or flost or cold liquitet or sour liquitet or sour liquitet or near liquitet or near liquitet of the following losing losing the dangerous the dangero	sing? ds/foods? quids/foods? quids/foods? your mot ss? wing we informa rately answ s and the the period	Hepatitis/Ja Sexually Tr Stomach Tr Stomach Tr It is? It is? It is? It is? It is? It is? It is is in the best wered. I understalth. I authorize arch. I understalth. I authorize arch. I work of such Demial	Yes Correction of the correcti	No Some state of the control of the	8. Do you have 9. Do you cle 10. Do you bit 11. Have you e following e 13. Have you have 14. Do you were 15. Have you e regarding to 16. Do you like tompany to pay payable to me. I bill for services.	vee eevevee haard di	freque ch or g your liper had traction d any of dentu- of place er recei e care o your sr irectly to inderstanagree to	Respiratory Problems Mitral Valve Prolapse Other Date of Last Exam Date of Last Cleaning ent headaches? rind your teeth? ps or cheeks frequently? any difficult extractions in the past? any prolonged bleeding ns? orthodontic treatment? res or partials? ement ived oral hygiene instructions of your teeth and gums? mile? to the dentist or dental group insurance of the dentist or dental insurance carrier may	Yes	No.
Ridney Diseases AIDS or HIV Infection Thyroid Problem Patient Dento Name of Previous Dentist Previous Dentists Location I. Do your gums bleed while bruse Previous Dentist's Location I. Do your teeth sensitive to hot I. Are your teeth sensitive to sweet I. Do you feel pain to any of your I. Do you feel pain to any of your I. Do you have any sores or lump I. Have you had any head, neck of I. Have you ever experienced any problems in your jaw? Clicking Pain (joint, ear, side of fact Difficulty in opening or cl Difficulty in chewing Authorization and Releacertify that I have read and underst nowledge. The above questions have reviding incorrect information can be release any information including symmination rendered to me or my of the problems in the property of the prope	shing or flost or cold liquitet or sour liquitet or sour liquitet or near liquitet or near liquitet of the following losing losing the dangerous the dangero	sing? ds/foods? quids/foods? quids/foods? your mot ss? wing we informa rately answ s and the the period	Hepatitis/Ja Sexually Tr Stomach Tr Stomach Tr It is? It is? It is? It is? It is? It is? It is is in the best wered. I understalth. I authorize arch. I understalth. I authorize arch. I work of such Demial	Yes Correction of the correcti	No Some state of the desired price of the desired p	8. Do you have 9. Do you cle 10. Do you bit 11. Have you e following e 13. Have you he 14. Do you we figer, date 15. Have you e regarding to 16. Do you like the company to pay payable to me. I bill for services, behalf or my dep X	di un la carrente de	freque ch or g your liper had traction d any of denture of place er receive e care of your sr irectly to indents.	Respiratory Problems Mitral Valve Prolapse Other Date of Last Exam Date of Last Cleaning ent headaches? rind your teeth? ps or cheeks frequently? any difficult extractions in the past? any prolonged bleeding ns? orthodontic treatment? res or partials? ement ived oral hygiene instructions of your teeth and gums? mile? to the dentist or dental group insurance of the dentist or dental insurance carrier may	Yes	N C
Ridney Diseases AIDS or HIV Infection Thyroid Problem Patient Dento Name of Previous Dentist Previous Dentists Location Dentise Location Dentise Location Are your teeth sensitive to hot Are your teeth sensitive to sweet Do you feel pain to any of your Do you have any sores or lump Have you had any head, neck of Have you ever experienced any problems in your jaw? Clicking Pain (joint, ear, side of fact Difficulty in opening or of Difficulty in opening or of Difficulty in chewing Authorization and Releacertify that I have read and unders nowledge. The above questions have release any information including samination rendered to me or my opening or endered to me or my op	shing or flost or cold liquitet or sour liquitet or sour liquitet or near liquitet or near liquitet of the following losing losing the dangerous the dangero	sing? ds/foods? quids/foods? quids/foods? your mot ss? wing we informa rately answ s and the the period	Hepatitis/Ja Sexually Tr Stomach Tr Stomach Tr And the sexually Tr Stomach Tr And the sexually Tr And Tr An	Yes Correction of the correcti	No Some state of the desired price of the desired p	8. Do you have 9. Do you cle 10. Do you bit 11. Have you e following e 13. Have you he 14. Do you we figer, date 15. Have you e regarding to 16. Do you like the company to pay payable to me. I bill for services, behalf or my dep X	di un la carrente de	freque ch or g your liper had traction d any of denture of place er receive e care of your sr irectly to indents.	Respiratory Problems Mitral Valve Prolapse Other Date of Last Exam Date of Last Cleaning ent headaches? rind your teeth? ps or cheeks frequently? any difficult extractions in the past? any prolonged bleeding ns? orthodontic treatment? res or partials? ement ived oral hygiene instructions of your teeth and gums? mile? to the dentist or dental group insurance in that my dental insurance carrier may be responsible for payment of all services.	Yes	N C C C C C C C C C C C C C C C C C C C