

Date of Last X-Rays: Burning Sensation on Tongue		_					
Patient Name: Relationship to Patient? Insurance Company: Insuranc	Patient Information	Dei	ntal Insurance				
Patient Name: Relationship to Patient? Insurance Company: Insuranc	Date:		Who is Responsible for this Account?				
Patient Social:							
Phone: Home							
Additional Insurance Company: City: State: Zip Code: Assignment and Release: E-Mail: Sex: M							
City: State: Zip Code: Assignment and Release: learning for the last of the following: Signature:			•				
State:	Address:	Addi	tional Insurance Comp	oany:			
E-Mail:	City:						
Sex: M F Age: Birthdate: and assign directly to Dr. Married Widowed Single Minor insurance benefits, if any, otherwise payable to me for any services rendered. Divorced Partnered for years I understand that I am financially responsible for all charges whether or not Decupation:	State: Zip Code:	Assig	Assignment and Release:				
Sex: M F Age: Birthdate: and assign directly to Dr. Married Widowed Single Minor insurance benefits, if any, otherwise payable to me for any services rendered. Divorced Partnered for years I understand that I am financially responsible for all charges whether or not Decupation:	E-Mail:	I certi	I certify, that I, and-or my dependents have insurance coverage with				
□ Married □ Widowed □ Single □ Minor insurance benefits, if any, otherwise payable to me for any services rendered. □ Divorced □ Partnered for							
Divorced Partnered foryears							
Occupation:	C						
Patient Employer/School:							
The above-named dentist may use my healthcare information and may disclose such information to the above-named insurance company for the purpose of obtaining payment of services and determining insurance benefits. Name: Phone: Signature: Phone: Signature: Phone: Ph							
disclose such information to the above-named insurance company for the purpose of obtaining payment of services and determining insurance benefits. Name:	Patient Employer/School:						
IN CASE OF EMERGENCY, CONACT: Name:							
Phone: Signature: Relationship to Patient: Place a mark on "yes" or "no" if you have had any of the following:		disclo	disclose such information to the above-named insurance company for the				
Reason for Today's Visit: Place a mark on "yes" or "no" if you have had any of the following: Place a mark on "yes" or "no" if you have had any of the following:	IN CASE OF EMERGENCY, CONACT:	purpo	purpose of obtaining payment of services and determining insurance benefits.				
Reason for Today's Visit: Place a mark on "yes" or "no" if you have had any of the following: City: State: Bad Breath Yes No No Nouth Pain Yes No No Pain around Ear Yes No No No Pain around Ear Yes No No No Pain around Ear Yes No No No No No No No N	Name: Phone:	Signa	Signature:				
Reason for Today's Visit: Place a mark on "yes" or "no" if you have had any of the following: Former Dentist:	Relationship to Patient:						
Reason for Today's Visit: Place a mark on "yes" or "no" if you have had any of the following: Former Dentist:	•						
Reason for Today's Visit: Place a mark on "yes" or "no" if you have had any of the following: Former Dentist:	Dontal History						
Former Dentist: had any of the following: Mouth Breathing Yes No Nouth Breathing Yes No Nouth Breathing Yes No Nouth Breathing Yes Nouth Bleeding Gums Yes Nouth Breathing Yes Nouth Breath	Dental History						
Former Dentist: had any of the following: Mouth Breathing Yes No Nouth Breathing Yes No Nouth Breathing Yes No Nouth Breathing Yes Nouth Bleeding Gums Yes Nouth Breathing Yes Nouth Breath	Reason for Today's Visit:	Place a mark on "yes" or "	'no" if you have				
City: State: Bad Breath Yes No Mouth Pain Yes No Date of Last Dental Visit: Blisters on Lips or Mouth Yes No Periodontal Treatment Yes No Date of Last X-Rays: Burning Sensation on Tongue Yes No Sensitivity to Temperature Yes No Chew on one Side of Mouth Yes No Sensitivity to Biting Yes No Clicking or Popping of Jaw Yes No Day sleepiness Yes No Dry Mouth Yes No Sonoring Yes No Fingernail Biting Yes No Sonoring Yes No Day sleepiness Yes No Sonoring Yes No Day sleepiness Yes		had any of the following:	·				
Date of Last Dental Visit: Date of Last X-Rays: What did you dislike at your previous office? Date of Last X-Rays: What did you dislike at your previous office? Date of Last X-Rays: Date of Last Dental Visit:		_	□ Vag □ No	<u>e</u>			
Date of Last X-Rays: Date of Last X-Rays: What did you dislike at your previous office? Cigarette-Pipe-Cigar Smoking Clicking or Popping of Jaw Dry Mouth Fingernail Biting Blisters on Lips or Mouth Periodontal Treatment Yes □ No Sensitivity to Temperature Yes □ No Sensitivity to Biting Yes □ No Sores in your Mouth Yes □ No Day sleepiness Yes □ No No Yes □ No Yes □ No Ory Mouth Yes □ No Ory Sores in your Mouth Yes □ No Ory Sores in your Mouth Yes □ No Ory Sores in Yes □ No Ory Sores □ No Ory Sores in Yes □ No Ory Sores □ No Ory		Planding Gums					
What did you dislike at your previous office? Chew on one Side of Mouth Cigarette-Pipe-Cigar Smoking Clicking or Popping of Jaw Dry Mouth Fingernail Biting Chew on one Side of Mouth Yes □ No Sensitivity to Biting Yes □ No Sores in your Mouth Yes □ No Day sleepiness Yes □ No Snoring Yes □ No Yes □ No Onoring Yes □ No Onoring	Date of Last Dental Visit:	Blisters on Lips or Mouth	□ Yes □ No		□ Yes □ No		
Cigarette-Pipe-Cigar Smoking					□ Yes □ No		
Clicking or Popping of Jaw □ Yes □ No Day sleepiness □ Yes □ No Dry Mouth □ Yes □ No Snoring □ Yes □ No Fingernail Biting □ Yes □ No	What did you dislike at your previous office?						
Dry Mouth □ Yes □ No Snoring □ Yes □ No Fingernail Biting □ Yes □ No							
Fingernail Biting				• 1	□ Yes □ No		
Food Collection between Teeth Ves I No. Floss.			□ Yes □ No	C			
		Food Collection between Te		Floss:			
Grinding Teeth □ Yes □ No □ Daily □ Weekly □ I could improve				□ Daily □ Weekly □ I co	ould improve		
Gums Swollen-Tender □ Yes □ No Jaw Pain-Tiredness □ Yes □ No Brush:				Dungha			
Jaw Pain-Tiredness □ Yes □ No Brush: Lips or Cheek Biting □ Yes □ No □ 1x Day □ 2x Day							

Loose Teeth Loose Fillings □ Yes □ No □ Human, and sometimes I get lazy at night

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 \square Yes \square No

Health History

Physician's Name: Date of La			Date of Last Vis	t Visit:		
Place a mark on "yes" or	"no" if you have had	d any of the following:				
	-		**	DI C. E	T	
AIDS-HIV	□ Yes □ No	Epilepsy	□ Yes □ No	Rheumatic Fever	□ Yes □ No	
Anemia Arthritis	□ Yes □ No	Fainting or Dizziness Glaucoma	□ Yes □ No □ Yes □ No	STDs	□ Yes □ No	
	□ Yes □ No	Headaches	□ Yes □ No	Shortness of Breath Sinus Trouble	□ Yes □ No	
Artificial Heart Valves Artificial Joints	□ Yes □ No □ Yes □ No		□ Yes □ No		□ Yes □ No	
Asthma	□ Yes □ No	Heart Murmur Heart Problems	□ Yes □ No	Skin Rash	□ Yes □ No □ Yes □ No	
Back Problems	□ Yes □ No			Sleep Apnea Stroke	□ Yes □ No	
Bacterial Endocarditis	□ Yes □ No	Hepatitis Type Herpes	□ Yes □ No □ Yes □ No	Swollen Feet Ankles	□ Yes □ No	
Bleeding Abnormally,		High Blood Pressure	□ Yes □ No	Thyroid Problems	□ Yes □ No	
Extractions or Surgery	□ Vas □ No	Jaundice	□ Yes □ No	Tonsillitis	□ Yes □ No	
Blood Diseases	□ Yes □ No	Jaw Pain	□ Yes □ No	Tuberculosis	□ Yes □ No	
Cancer	□ Yes □ No		□ Yes □ No			
	□ Yes □ No	Kidney Disease Liver Disease	□ Yes □ No	Tumor or Growth	□ Vos. □ No.	
Chemotherapy	□ Yes □ No	Low Blood Pressure	□ Yes □ No	Head, Neck, or Mouth	□ Yes □ No	
Circulatory Problems			□ Yes □ No	Ulcers		
Congenital Heart Disease Cortisone Treatments	□ Yes □ No	Mitral Valve Prolapse Nervous Problems				
			□ Yes □ No □ Yes □ No			
Diabetes	□ Yes □ No	Pacemaker	□ Yes □ No			
Emphysema	□ Yes □ No	Radiation Treatment				
Women:						
Pregnant?	ant?			Please Provide if Pregnant:		
On Birth Control Pills?	□ Yes □ No	Nursing:	□ Yes □ No	OB-GYN Name: OB-GYN Phone:		
Medications				Allergies		
Please List Any Current P	•			□ Codeine		
Over the Counter Medications, or				□ Latex		
Supplements:		Corresponding Diagnosis:				
				□ Penicillin		
				□ Other:		
				OR		
				□ No Known Drug Alle	ergies	
		Patient Sign	ature	Date		
		Doctor Sign	Doctor Signature		Date	