Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us we will be happy to help.

Patient # \_\_\_\_\_\_

Patient Information (CONFIDENTIAL)  NameBirthdateHome Phone State/ Zip/ ProvP.C	MU			D.:
Patient Information (CONFIDENTIAL)    Date				Patient #
Name Birthdate Blome Phone State Prov. Proc. Prov. Proc. Prov. Proc. Prov. Proc. Prov. Proc. Prov. Pro	Dationt Inform	ation (content	TATOM AT	
Cell Phone	2			
Cell Phone				Home Phone State/ Zip/
Check Appropriate Box:   Minor   Single   Married   Divorced   Widowed   Separated   State   Fold   Part   Student, Name of School/College   City   Foot   Time   Time   Time   Time   Part   Student, Name of School/College   City   Foot   Time   Time   Time   Time   Part   Student, Name of School/College   City   Foot   Foo	Address		City	
Patient or Parent/Guardian's Employer Business Address   City   Prov.   Prov.	Email			
Patient or Parent/Guardian's Employer Business Address   City   Prov.   Prov.	Check Appropriate Box: Minor	$\square$ Single $\square$ Married $\square$ I	Divorced	Separated State/ Full Part
Business Address City Prov Pr.C.  Spouse or Parent/Guardian's Name Employer Work Phone  Whom may we thank for referring you?  Person to contact in case of emergency Phome  Responsible Party  Relationship to Patient Address Cell Phone  Prover's License# Birthdate Financial institution  Employer Work Phone St#/SIN St 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 Payment in full at each appointment.  Cash Personal Check Credit Card VISA MasterCard I wish to discuss the offices payment policy.  Insurance Information  Name of Insured  SS#/SIN Date Employed  Work Phone Styling  Relationship to Patient  To Patient  Line Employed  Work Phone Styling  SS#/SIN Date Employed  Work Phone I Styling  Relationship to Patient  To Patient  Line Employed  Work Phone I Styling  Relationship to Patient  Relationship to Patient  To Patient  Line Employed  Work Phone I Styling  Relationship to Patient  Relationship to Patient  To Patient  Name of Employer Union or Local# Work Phone I State  The Consumance Company Group# PolicyID# State  DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:  Name of Insured Relationship to Patient  Date Employed  Name of Employer Union or Local# Work Phone I State  Relationship to Patient  Relationship to Patient  Date Employed  Work Phone I State  The Consumance Company Group# PolicyID# State  Prov.	, , ,			
Spouse or Parent/Guardian's Name				Statel 7in/
Person to contact in case of emergency Phone Relationship to Pattent  Responsible Party Name of Person Responsible for this Account Cell Phone Phone Phone Cell Phone Phone Cell Phone Phone Cell Phone Phone Phone Cell Phone Phone Phone Phone Cell Phone Phone Cell Phone Phone Cell Phone Phone Phone Phone Phone Cell Phone Ph		**************************************		
Phone   Present to contact in case of emergency   Phone	15C	ise or Parent/Guardian's NameEmployer		
Responsible Party Name of Person Responsible For this Account Address				
Name of Person Responsible for this Account  Address	Person to contact in case of emerg	ency		Phone
Name of Person Responsible for this Account  Address	Responsible Pa	artv		
Address				
Email	2			
Birthdate				
Work Phone				
Is this person currently a patient in our office?				
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.    Cash	M. 50			
□ Cash □ Personal Check Credit Card □ VISA □ MasterCard □ I wish to discuss the office's payment policy.  Insurance Information  Name of Insured □ SS#/SIN □ Date Employed □ Work Phone □ State □ Zip/□ Prov. □ Prov.				refer Payment in full at each annointment
Insurance Information  Name of Insured				
Name of Insured SS#/SIN Date Employed State/ Zip/ Prov. P.C. Insurance Company Group# State/ Zip/ Prov. P.C. Insurance of Insured Birthdate SS#/SIN Distribution or Local# State/ Zip/ Prov. P.C. Insurance Company Group# Policy/ID# State/ Zip/ Prov. P.C. Insurance Company Group# Prov. P.C. Insurance Company Group# State/ Zip/ Prov. P.C. Insurance Company Birthdate SS#/SIN If YES, COMPLETE THE FOLLOWING:  Name of Insured Relationship to Patient Birthdate SS#/SIN Date Employed State/ Zip/ Prov. P.C. Insurance Company Group# Prov. P.C. Insurance City Prov. P.C. Insurance Cit			1 Dividiter Cara	T wish to discuss the offices payment policy.
Birthdate SS#/SIN Date Employed Mork Phone State Zip/ Prov. P.C. Insurance Company Group# Policy/ID# State/ Zip/ Prov. P.C. Insurance Company Group# Policy/ID# State/ Zip/ Prov. P.C. Insurance Company Group# Policy/ID# State/ Zip/ Prov. P.C. Insurance Company Prov. P.C. Insurance Company Prov. P.C. Insurance Company Policy/ID# State/ Zip/ Prov. P.C. Insurance Company Policy/ID# State/ Zip/ Prov. P.C. Insurance Company Prov. P.C. Insurance Company Prov. P.C. Insurance Company Policy/ID# State/ Zip/ Prov. P.C. Insurance Company Prov. P.C. Insurance Company Policy/ID# State/ Zip/ Prov. P.C. Insurance Company Policy/ID# State/ Zip/ Prov. P.C. Insurance Company Prov. P.C. Insurance Company Prov. P.C. Insurance Company Prov. P.C. Insurance Company Policy/ID# State/ Zip/ Prov. P.C. Insurance Company Prov. P.C. Insurance Compan	insurance injo	rmation		D-1-4:1:
Name of Employer	Name of Insured			Relationship to Patient
Insurance Company Group# Policy/ID# State/ Zip/ Prov. P.C.  How much is your deductible? How much have you used? Max. annual benefit DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:  Name of Insured Relationship to Patient Birthdate SS#/SIN Date Employed Work Phone State/ Zip/ Prov. P.C.  Address of Employer City Prov. P.C.  Insurance Company Group# Policy/ID# State/ Zip/ Prov. P.C.	Birthdate	SS#/SIN		Date Employed
Insurance Company Group# Policy/ID# State/ Zip/ Prov. P.C.  How much is your deductible? How much have you used? Max. annual benefit DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:  Name of Insured Relationship to Patient Birthdate SS#/SIN Date Employed Work Phone State/ Zip/ Prov. P.C.  Address of Employer City Prov. P.C.  Insurance Company Group# Policy/ID# State/ Zip/ Prov. P.C.	Name of Employer		Union or Local#	Work Phone
Insurance Company Group# Policy/ID# State/ Zip/ Prov. P.C.  How much is your deductible? How much have you used? Max. annual benefit DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:  Name of Insured Relationship to Patient Birthdate SS#/SIN Date Employed Work Phone State/ Zip/ Prov. P.C.  Address of Employer City Prov. P.C.  Insurance Company Group# Policy/ID# State/ Zip/ Prov. P.C.	Address of Employer		City	
How much is your deductible? How much have you used? Max. annual benefit  DO YOU HAVE ANY ADDITIONAL INSURANCE?				
How much is your deductible? How much have you used? Max. annual benefit  DO YOU HAVE ANY ADDITIONAL INSURANCE?	Ins. Co. Address		City	State/ Zip/ ProvP.C
Name of Insured				
Birthdate         SS#/SIN         Date Employed           Name of Employer         Union or Local#         Work Phone State/ Zip/ Prov.           Address of Employer         City         Prov.         P.C.           Insurance Company         Group#         Policy/ID# State/ Zip/ Prov.         Prov.         P.C.           Ins. Co. Address         City         Prov.         P.C.	DO YOU HAVE ANY ADDITIO	ONAL INSURANCE? ☐ Yes	S □ No IF YES, O	COMPLETE THE FOLLOWING:
Birthdate         SS#/SIN         Date Employed           Name of Employer         Union or Local#         Work Phone State/ Zip/ Prov.           Address of Employer         City         Prov.         P.C.           Insurance Company         Group#         Policy/ID# State/ Zip/ Prov.         Prov.         P.C.           Ins. Co. Address         City         Prov.         P.C.	Name of Insured			Relationship to Patient
Name of Employer	~			
Address of Employer City State/ Zip/ Prov P.C				Work Phone
Insurance Company         Group#         Policy/ID#           Ins. Co. Address         City         Prov.         P.C.	15) 5 5			State/ Zip/
Ins. Co. Address City Staté/ Zip/ ProvP.C			• (0.100,000,000,000,000,000,000,000,000,00	
				Statel 7in/
			THE RESERVE THE PROPERTY OF TH	

## **Patient Medical History** Office Phone Physician Date of Last Exam \_\_\_ No 1. Are you under medical treatment now? ..... 10. Are you wearing contact lenses? ..... 11. Are you allergic to or have you had any reactions to the following? 2. Have you ever been hospitalized for any Local Anesthetics (e.g. Novocain) ..... surgical operation or serious illness within the last 5 years?..... Penicillin or any other Antibiotics ..... If yes, please explain \_\_\_\_ Sulfa Drugs ..... Barbiturates ..... 3. Are you taking any medication(s) Sedatives..... including non-prescription medicine? Iodine..... If yes, what medication(s) are you taking? Any Metals (e.g. nickel, mercury, etc.) ..... 4. Have you ever taken Fen-Phen/Redux? ..... Latex Rubber 5. Have you ever taken Fosamax, Boniva, Actonel or any cancer Other (please list) \_\_\_\_\_ medications containing bisphosphonates? 12. Do you have a persistent cough or throat clearing not 6. Have you taken Viagra, Revati, Cialis or Levitra associated with a known illness (lasting more than 3 weeks)?..... in the last 24 hours? 7. Do you use tobacco? ..... a) Are you pregnant or think you may be pregnant? ..... 8. Do you use controlled substances? ..... b) Are you nursing? ..... 9. Do you have or have you had any of the following? c) Are you taking oral contraceptives?..... High Blood Pressure ..... Chest Pains ..... Heart Disease ..... Heart Attack ..... Easily Winded ..... Cardiac Pacemaker ..... Rheumatic Fever ..... Heart Murmur ..... Stroke ..... Swollen Ankles Angina ..... Hay Fever / Allergies ..... Fainting / Seizures ..... Frequently Tired ..... Tuberculosis ..... Asthma ..... Anemia ..... Radiation Therapy ..... Low Blood Pressure ..... Emphysema ..... Glaucoma ..... Recent Weight Loss ..... Epilepsy / Convulsions ..... Cancer ..... Leukemia ..... Arthritis ..... Liver Disease ..... Diabetes ..... Heart Trouble ..... Joint Replacement or Implant ..... Respiratory Problems ..... Kidney Diseases ..... Hepatitis / Jaundice ..... AIDS or HIV Infection ..... Sexually Transmitted Disease ..... Mitral Valve Prolapse ..... Stomach Troubles / Ulcers ..... Thyroid Problem ..... Patient Dental History Name of Previous Dentist and Location\_ Date of Last Exam \_\_ 1. Do your gums bleed while brushing or flossing?..... 8. Do you have frequent headaches?.... 2. Are your teeth sensitive to hot or cold liquids/foods?..... 9. Do you clench or grind your teeth?..... 3. Are your teeth sensitive to sweet or sour liquids/foods?..... 10. Do you bite your lips or cheeks frequently?..... 4. Do you feel pain to any of your teeth?.... 11. Have you ever had any difficult extractions 5. Do you have any sores or lumps in or near your mouth?..... in the past? 6. Have you had any head, neck or jaw injuries? ..... 12. Have you ever had any prolonged bleeding 7. Have you ever experienced any of the following following extractions? ..... problems in your jaw? 13. Have you had any orthodontic treatment?..... Clicking ..... 14. Do you wear dentures or partials?.... Pain (joint, ear, side of face) ..... If yes, date of placement \_ Difficulty in opening or closing ..... 15. Have you ever received oral hygiene instructions Difficulty in chewing ..... regarding the care of your teeth and gums? ..... 16. Do you like your smile? ..... Authorization and Release I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist 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. I agree to be responsible for payment of all services rendered on my behalf or my dependants. Signature of patient (or parent/guardian if minor) Doctor's Comments\_

Signature\_

Date

PATT L. .3ON OFFICE SUPPLIES 1.800.637.1140 051-1030/16790