WELCOME TO THE PRACTICE!

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CONFIDENTIALITY NOTICE

We do not share patient information with any other party and comply with the Health Insurance Protection and Portability Act as instituted by federal legislation. Only YOU can request copies of your records and such requests must be in writing.

PATIENT I	NFORMATION							
Name:								
(LAST)	(FIRST)	(M.I.)						
Address:								
City:	State:	_Zip:						
Home Phone:	Work Phone:							
Cell Phone:	Emerg. Phone:_							
e-Mail:	@							
Date of Birth://SSN:								
Drivers License:	MBER)	(STATE)						
CDAUCE I	NEADMATIAN							
SPOUSE INFORMATION Marital Status: □Single □Married □Sep □Divorced □Widowed								
Spouses Name:								
Date of Birth://	SSN:	-						
Insurance Coverage for Spouse	on your policy: \square	Yes □ No						
Insurance Coverage from Spous	se's Policy: Yes	□ No						
PATIENT 'S EMPL	OYER INFORM	ATION						
Employer:								
Phone:Occu	pation:							

ATTENTION: PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT.

INSURANCE INFORMATION **Primary Insurance Policy** Insured Name: Relationship to Patient: ☐ Self ☐ Spouse ☐ Child Insured's SSN: - - Subscriber Pt. here? ☐ Yes Carrier Name: Policy (Group or Plan)#:_____ Member #: Employer:_____ Fee Schedule:_____ Type: ☐ Indemnity ☐ PPO ☐ Discount ☐ Managed Care **Secondary Insurance Policy** Insured Name: Relationship to Patient: ☐ Self ☐ Spouse ☐ Child Insured's SSN: ____-_Subscriber Pt. here? ☐ Yes Carrier Name: Policy (Group or Plan)#: Member #: Employer: Fee Schedule: Type: ☐ Indemnity ☐ PPO ☐ Discount ☐ Managed Care

EMERGENCY CONTACT INFORMATION

In an emergency, please provide a name and phone number of someone we should we contact on your be-Their Name: Relationship: Phone:

NOTICE TO PARENTS WITH MINOR CHILDREN

No patient under 18 years of age will be treated or examined without a legal guardian present during the entire dental appointment, unless emancipated.

(SIGNATURE OF PATIENT) (DATE) (SIGNATURE OF DENTIST) (DATE)		MEDICAL HISTORY QUESTIONNAIRE									
Doctor's Name	Patient Name:					Date:					
2. List all medications taken in the last six months: Are you sensitive or allergic to any medication?	1.				g the pa	ast two years?			□Yes	□ No	
3. Are you sensitive or allergic to any medication?		Doct	or's Name	Condition /	Treatr	nent	Date				
3. Are you sensitive or allergic to any medication?											
3. Are you sensitive or allergic to any medication?											
3. Are you sensitive or allergic to any medication?											
4. Are you receiving or have you received treatment for Periodontal Disease?	2.	List all medications taken in the	last six months:								
4. Are you receiving or have you received treatment for Periodontal Disease?											
Do you anticipate becoming pregnant?	4. 5.	Are you receiving or have you re Has a physician ever told you to Have you had an artificial joint p	eceived treatment for pre-medicate with placed within the pr	or Periodontal Disea an antibiotic before evious two years?	se? dental	treatment?			☐ Yes ☐ Yes ☐ Yes	□ No □ No □ No	
Are you taking birth control pills? Please circle any of the following conditions which you have been diagnosed with by a physician: Please circle any of the following conditions which you have been diagnosed with by a physician: Particle Parti	7.	WOMEN ONLY: Are you	u pregnant?	 na prognant?					☐ Yes		
Cardiovascular (Heart/Circulation) 1. Heart murmur 2. Rheumatic fever 3. Mitral valve prolapse 4. Artificial hear valve 4. Chemotherapy 5. High blood pressure (hypertension) 6. Low blood pressure (hypertension) 7. Heart disease and / or heart attack 8. Angina pectoris / heart related chest pain 9. Heart pacemaker 10. Heart surgery / vascular stent / by-pass surgery 11. Liver disease 12. Asthma 13. Sinus problems if so, have you had infections? □ Yes 14. Elevated liver enzymes 15. Excessive bleeding 16. Hepatitis A Hepatitis B Hepatitis C Other 17. Jaundice 18. G.I. disorder / Crohns Dz. / Diverticulitis / IBS / Other Neurological 19. Parkinson disease 10. Isorder / Crohns Dz. / Diverticulitis / IBS / Other Neurological 10. Parkinson disease 11. Parkinson disease 12. Atthma 13. Gar removal or transplant 14. Thyroid disease (syphilis, gonorrhea, herpes) 15. Arthritis - Osteo / Rheumatoid 16. Hemophilia 17. Venereal disease (syphilis, gonorrhea, herpes) 18. G.I. disorder / Crohns Dz. / Diverticulitis / IBS / Other Neurological 19. Glaucoma Neurological 10. Parkinson disease 21. Attention deficit disorder / hyperactivity (ADD / ADHD) 22. Psychiatric treatment (depression, anxiety, panic disorder) Dental History 10. Diabetes: Type I (Juvenile) Type II (Adult Onset) 11. Gastric Ulcers 12. Asthma 13. Sinus problems if so, have you had infections? □ Yes 14. Thyroid disease 15. Arthritis - Osteo / Rheumatoid 16. Hemophilia 17. Venereal disease (syphilis, gonorrhea, herpes) 18. Organ removal or transplant 19. Glaucoma 19. Glaucoma 19. Glaucoma 10. Porstate / Urinary tract problems 11. Adult or juvenile periodontal disease 12. Tempromandibular joint dz. (TMJ) 13. Bruxism - grinding of teeth causing wear 14. Mouth ulcers - Lichen planus - aphthous ulcers 17. Alzheimer's Dz. or dementia 18. Glorature of Patenti) 19. Glaucoma 19. Glaucoma 20. Prostate / Urinary tract problems 21. Attention deficit discorder / hyperactivity (ADD / ADHD) 22. Psychiatric trea											
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