

Melcome

Patient Information (CONFIDENTIAL) Name	Thank you for selecting our dental healthca We will strive to provide you with the best p dental healthcare needs, please fill out this or need assistance, please ask us - we will b	possible dental care. To help us meet all your form completely in ink. If you have any questions	Patient # SS#/SIN		
Name Birthdate Home Phone State Address City Prov. P.C.					
Email Gell Phone Gell Phone	Patient Intor	mation (CONFIDENTIAL)			
Email Gell Phone Gell Phone	Name	Birthdate	_ Home Phone _	7:0/	
Email Gell Phone Gell Phone	Address	City		P.C	
Do you prefer to receive calls at your:	Email Email	Cell Phone			
Check Appropriate Box: Minor Single Married Divorced Widowed Separated Stated, Time Time	Do you prefer to receive calls at your:	☐ Home ☐ Work ☐ Cell Phone			
If Student, Name of School/College Patient or Parent/Guardian's Employer Business Address City State/ Spouse or Parent/Guardian's Name Employer Work Phone Whom may we thank for referring you? Person to contact in case of emergency Phone Responsible Party Name of Person Responsible for this Account Address Email Priver's License# Birthdate Birthdate Birthdate Institution Employer Birthdate SS#/SIN Some of Personal Check Credit Card \ \text{VISA} \ \text{MasterCard} \ \text{I wish to discuss the office's payment policy.} Insurance Company State/ Birthdate SS#/SIN Date Employed Address City Prov. Pic. How much have you used? Name of Insured Birthdate SS#/SIN Dot Employer How much have you used? Name of Insured Birthdate SS#/SIN Dot Employed Name of Insured Birthdate SS#/SIN Dot QU HAVE ANY ADDITIONAL INSURANCE? Very Roc. Address Group # State/ State/ State/ Prov. Pic. Insurance Company Name of Employer Union or Local # State/ State/ Pic. Prov. Pic. Insurance Company Name of Insured Birthdate SS#/SIN Do you HAVE ANY ADDITIONAL INSURANCE? Union or Local # State/ State/ Pic. Prov. Pic. Insurance Company Name of Employer Union or Local # State/ Pic. Prov. Pic. Pic. Insurance Company Name of Employer Address Oroup # State/ Pic. Pic. Pic. Prov. Pic. Pic. Pic. Prov. Pic. Pic. Prov. Pic. Pinsurance Company Name of Employer Address Oroup # State/ Prov. Pic. Pinsurance Company Name of Employer Address Oroup # State/ Prov. Pic. Pinsurance Company Name of Employer Address Oroup # State/ Pic. Pic. Pinsurance Company Name of Employer Address Oroup # State/ Pic. Pinsurance Company Name of Employer Address Oroup # State/ Pic. Pinsurance Company Name of Employer Address Oroup # Pic. Pinsurance Company Oroup Pinsurance Oroup # Pic. Pinsurance Company Oroup Pinsurance Oroup Pinsurance Oroup Pinsurance Oroup Pinsurance Oroup Pinsurance Oroup Pins			parated State/	Full P	art
Business Address City State/ Ziv. Business Address Employer Work Phone Whom may we thank for referring you? Person to contact in case of emergency Phone Responsible Party Relationship to Patient Address Home Phone Cell Phone Priver's License# Birthdate Financial Institution Birthdate Financial Institution 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 office's payment policy. Insurance Imformation Name of Insured SS#/SIN Name of Employer Union or Local # Address of Employer Gity Prov. PC. No How much is your deductible? How much have you used? Name of Insured SS#/SIN Do YOU HAVE ANY ADDITIONAL INSURANCE? Yes No Name of Insured SS#/SIN Date Employed Name of Insured Prov. PC. No For your convenience of Employer Gity Prov. PC. Name of Insured SISH/SIN Date Employed Name of Employer City Prov. PC. Name of Employer Group # Name of Employer Group # Name of Employer Group # Name of Employer Prov. PC. Name of Employer Prov. PC. Name of Insured SS#/SIN Date Employed Name of Employer City Prov. PC. Name of Employer Prov. PC. Name of Employer City Prov. PC. Name of Insured SS#/SIN Date Employed Name of Employer City Prov. PC. Name of Employer City Prov	If Student, Name of School/College	City		Time Ti	me
Spouse or Parent/Guardian's Name	Patient or Parent/Guardian's Employer		_ Work Phone	7:/	
Spouse or Parent/Guardian's Name	Business Address	City	State/ Prov	_ P.C	
Person to contact in case of emergency Phone Prone Responsible Party Name of Person Responsible for this Account Address Email Cell Phone	Spouse or Parent/Guardian's Name	Employer	Work Phone _		
Responsible Party Name of Insured Birthdate SS#/SIN Name of Employer Name of Insured Birthdate SS#/SIN State/					
Name of Person Responsible for this Account Address	Person to contact in case of emergency		Phone		_
Address	Responsible	Party	Relationship		
Email	Name of Person Responsible for this Account				
Email	Address		_ Home Phone _		
Birthdate Financial Institution SS#/SIN	Fmail		Cell Phone		
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. Payment in full at each appointment. Cash	Driver's License#	Birthdate Financial Institution _			
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. Payment in full at each appointment. Cash	Employer	Work Phone	SS#/SIN		
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 office's payment policy. Insurance Insurance	Is this person currently a patient in our offic	re? Yes No			
Name of Insured	For your convenience we offer the following	methods of payment. Please check the option you prefer. Pay	ment in full at ea	ch appointment	
Name of Insured			o discuss the offic	e's payment po	lıcy.
Name of Insured	Incurance Ir	formation	2.1		
Birthdate			Relationship to Patient		
Name of Employer	Name of Insured	C#/CINI	Date Employe	d	
Insurance Company Group # Policy/ID #		Union or Local #	Work Phone .		
Insurance Company Group # Policy/ID #		City.	State/	Zip/ P.C.	
Ins. Co. Address	Address of Employer				
Ins. Co. Address How much have you used? Max. annual benefit DO YOU HAVE ANY ADDITIONAL INSURANCE?			State/	Zip/	
DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes	Ins. Co. Address	City	FIOV		
Relationship to Patient	How much is your deductible?				
Name of Insured to Patient Birthdate SS#/SIN Name of Employer Union or Local # Address of Employer City Insurance Company Group # Ins. Co. Address City Prov. PC. State/ Zip/ Prov. Prov. Prov. PC.	DO YOU HAVE ANY ADDITIONAL INS	URANCE? Yes No IF YES, COMP		OWING:	
Date Employed	Name of Insured				
Name of Employer Union or Local # Work Phone State/ Zip/ Prov. Zip/ Prov. Prov. P.C. Prov. P.C. P.C. P.C. Prov. P.C. P.C. <td>Rirthdate S</td> <td></td> <td> Date Employe</td> <td></td> <td></td>	Rirthdate S		Date Employe		
Address of Employer	Name of Employer	Union or Local #	Work Phone	7im/	
Insurance Company	Address of Employer	City	<i>State/</i> <i>Prov.</i>	P.C	
Ins. Co. Address City Prov. P.C.	Insurance Company	Group #	Policy/ID # _	7:/	
How much is your deductible? How much have you used? Max. annual benefit				P.C	
	How much is your deductible?	How much have you used? Me	ax. annual benefi	t	



Patient Medical History

Physician	Office Phone						Date of Last Exam		
1 4		Yes	No					Yes	No
1. Are you under medical treatment now?				10. Are	you w	earing o	contact lenses?	🔲	
2. Have you ever been hospitalized for any surgical operation or serious illness within the	last 5			11. Arey	ou aller	gic to or	have you had any reactions to the following?		
If yes, please explain	tust 5 years?			Peni	u Ane.	stnetics	(e.g. Novocain)	Ц	
33 71				Sulfa	a Dru	or uny o	other Antibiotics	-	
3. Are you taking any medication(s)				Bark	oiturat	ξ3 tρς		-	H
including non-prescription medicine? If yes, what medication(s) are you taking?				Seda	itives.			·· -	H
If yes, what medication(s) are you taking?				Iodir	пе				
4 ***				Aspi	rin				H
4. Have you ever taken Fen-Phen/Redux?				Any	Metal.	s (e.g. n	ickel, mercury, etc.)		
Have you ever taken Fosamax, Boniva, Actonel of medications containing bisphosphonates?	or any cancer		П	Late: Othe	x Rub	ber			
6. Have you taken Vigora Revatio Cialis or Lev	itva			12. Do yo	ou have	a persis	stent cough or throat clearing not	-	
in the last 24 hours?				associ 13. Wom	iated w	rith a kno	own illness (lasting more than 3 weeks)?		
7. Do you use tobacco?							nt or think you may be pregnant?		
8. Do you use controlled substances?			Ш	b) Ar	e you	nursing	??	· H	H
9. Do you have or have you had any of the follow	ing?			c) Ar	e you	taking d	oral contraceptives?		
	No.				Yes	No		Yes	No
High Blood Pressure	Heart Disease						Chest Pains		
Heart Attack	Cardiac Pacen						Easily Winded	🔲	П
Rheumatic Fever	Heart Murmu						Stroke	. 🔲	
Swollen Ankles	Angina						Hay Fever / Allergies	. 🔲	
Fainting / Seizures	Frequently Tire	ed					Tuberculosis		
Asthma Low Blood Pressure	Anemia						Radiation Therapy		
	_ Emphysema				Н		Glaucoma		
Epilepsy / Convulsions Leukemia	Cancer	•••••			Н	\vdash	Recent Weight Loss	. 🔲	
Diabetes	Arthritis				\mathbb{H}	\vdash	Liver Disease	. 📙	
Kidney Diseases	Joint Replacem	ent 01	ттри	int	H	H	Heart Trouble		Ц
AIDS or HIV Infection	Hepatitis / Jau Sexually Transi	naice.	1 Diag		H	H	Respiratory Problems	. Ц	
Thyroid Problem	Stomach Troub	muuea Aec / I	Toers	ise	H	H	Mitral Valve Prolapse Other	· -	Н
							Other	. 🗀	
Patient Denta	I MISU								
Name of Previous Dentist and Location							Date of Last Exam		
1.5		es 1	Vo					Yes	No
1. Do your gums bleed while brushing or flossing	g? L	<u> </u>	_	8. Do	you h	ave fred	quent headaches?		
2. Are your teeth sensitive to hot or cold liquids/	foods?	<u> </u>	_	9. Do	уои с	lench or	grind your teeth?		
3. Are your teeth sensitive to sweet or sour liquid	ls/foods?L	닉 누	4	10. Do	you b	ite your	· lips or cheeks frequently?		
4. Do you feel pain to any of your teeth?	L	-		11. Ha	ve you	ever ho	nd any difficult extractions		
5. Do you have any sores or lumps in or near you	ur mouth?	-	=	in t	the pa	st?	1 11 111 1		
6. Have you had any head, neck or jaw injuries? 7. Have you ever experienced any of the following	L			12.Hav	e you	ever ha	d any prolonged bleeding		
problems in your jaw?				foll	owing	extract	ions?	Н	
Clicking	Г	7 6					y orthodontic treatment?	H	\vdash
Pain (joint, ear, side of face)			=				tures or partials?		
Difficulty in opening or closing		7 F	=	15 H	es, aai	te of pla	cement		
Difficulty in chewing		i i		15. Ha	ve you	ever re	ceived oral hygiene instructions		
<i>"</i>			_	16 Do	vou li	ke vour	re of your teeth and gums? smile?	H	H
Authorization	and I	Da	1	10. 50		ne your	smuc:		
Authorization	allu	TE	110	203					
Payment is due in full at the time of This office accepts insurance, I understand that I deductibles that my insurance does not cover. I he to me. I understand that I am responsible for all crecords of treatment or examination rendered to I understand that the information that I have give the strictest confidence and it is my responsibility necessary dental services that I may need during	am responsible for pereby authorize payn costs of dental treatm my insurance compo en today is correct to to inform this office	paymenent dent. I any. of the both of an	ent of s lirectly hereby pest of y chan	to the Der to the Der y authorize my knowle ges in my	ndered ntal O e reled edge. I medid	l and al Office of ase of a Lalso un	so responsible for paying any co-paym the group insurance benefits otherwise ny information, including the diagnos	payab is and held in	ole
×									
Signature of patient (or parent/guardian if r	nr)				Thy I		Date		-
1 0							Duit		