CONFIDENTIAL

PATIENT	#		 51 1509001

DATE _____

(PLEASE PRINT)		DAIE
NAMEFIRST MI LAS	BIRTHDATE	HOME PHONE
FIRST MI LAS ADDRESS		STATE/ ZIP/ PROV P.C
E-MAIL		
CHECK APPROPRIATE BOX: MINOR PATIENT'S OR PARENT/GUARDIAN'S EMPLOYER	SINGLE MARRIED DI	VORCED WIDOWED SEPARATEE
BUSINESS ADDRESS	CITY	PROV P.C
SPOUSE OR PARENT/GUARDIAN'S NAME	EMPLOYER	WORK PHONE
IF PATIENT IS A STUDENT, NAME OF SCHOOL /	CITY SIA1E/ PROV	
WHOM MAY WE THANK FOR REFERRING YOU?		
PERSON TO CONTACT IN CASE OF AN EMERGE	NCY	PHONE
RESPONSIBLE PARTY		
NAME OF PERSON RESPONSIBLE FOR THIS A	ACCOUNT	RELATIONSHIP TO PATIENT
ADDRESS		HOME PHONE
E-MAIL		CELL PHONE
DRIVER'S LICENSE #	BIRTHDATE	FINANCIAL INSTITUTION
EMPLOYER		WORK PHONE
IS THIS PERSON CURRENTLY A PATIENT IN O	UR OFFICE? YES	NO
INSURANCE INFORMATION		
NAME OF INSURED		RELATIONSHIP
BIRTHDATE SS #/	SIN	DATE EMPLOYED
NAME OF EMPLOYER	WORK P	HONE
ADDRESS OF EMPLOYER	CITY	PROV. P.C.
INSURANCE COMPANY	GROUP #	UNION OR LOCAL # STATE/ ZIP/
INS. CO. ADDRESS		PROV P.C
HOW MUCH IS YOUR DEDUCTIBLE?		
DO YOU HAVE ANY ADDITIONAL INSUI	RANCE? YES NO	IF YES, COMPLETE THE FOLLOWING:
NAME OF INSURED		RELATIONSHIPTO PATIENT
BIRTHDATE SS #/	SIN	DATE EMPLOYED
NAME OF EMPLOYER	WORK P	HONE STATE/
ADDRESS OF EMPLOYER	CITY	PROV P.C
INSURANCE COMPANY	GROUP #	UNION OR LOCAL #
INS. CO. ADDRESS	CITY	PROV. P.C.
HOW MUCH IS YOUR DEDUCTIBLE?	HOW MUCH HAVE YOU USED?	MAX. ANNUAL BENEFIT?

PATIENT NAME HOME ADDRESS E-MAIL BUSINESS ADDRESS	DATE OF BIRTH HOME PHONE CELL PHONE	
	PATIENT MEDICAÉ HISTORY	
PHYSICIAN	OFFICE PHONE DATE OF LAST EXAM	100
	YES NO 8. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FO	li li
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	YES NO YES NO YES NO	
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	☐ LOCAL ANESTHETICS ☐ BARBITURATES ☐ AS (E.G. NOVOCAINE)	100
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	PENICILLIN OR OTHER SEDATIVES OF OTHER ANTIBIOTICS	HER
IF YES, WHAT MEDICATION(S) ARE YOU TAKING?	SULFA DRUGS IODINE	NO
4. HAVE YOU EVER TAKEN FEN-PHEN/REDUX?	9. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)?	
5. DO YOU USE TOBACCO?	☐ 10. WOMEN ONLY:	_
6. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUG	A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? B) ARE YOU NURSING?	
7. ARE YOU WEARING CONTACT LENSES?	C) ARE YOU TAKING BIRTH CONTROL PILLS?	
RHEUMATIC FEVER HEART HEART HEART SWOLLEN ANKLES ANGIN FREQUENT FREQUENT HEART HEA	YES NO DISEASE CHEST PAINS AC PACEMAKER STROKE HAY FEVER / ALLERGIES JENTLY TIRED RADIATION THERAPY YSEMA RECENT WEIGHT LOSS	DATE
	PATENT DERVA HISTORY - POPE LE PAR L'AR	No water
 DO YOUR GUMS BLEED WHILE BRUSHING OR F ARE YOUR TEETH SENSITIVE TO HOT OR COLD L ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR DO YOU FEEL PAIN TO ANY OF YOUR TEETH? DO YOU HAVE ANY SORES OR LUMPS IN OR NE HAVE YOU HAD ANY HEAD, NECK OR JAW INJUR HAVE YOU EVER EXPERIENCED ANY OF THE FOL PROBLEMS IN YOUR JAW? A) CLICKING? B) PAIN (JOINT, EAR, SIDE OF FACE) C) DIFFICULTY IN OPENING OR CLO 	9. DO YOU CLENCH OR GRIND YOUR TEETH? 10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY 11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST? 12. HAVE YOU HAD ANY ORTHODONTIC WORK? 13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS? 14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?	W 10 - 02
	ND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN A G INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.	ACCURATELY ANSWERED.

PATIENT, PARENT OR GUARDIAN

DATE