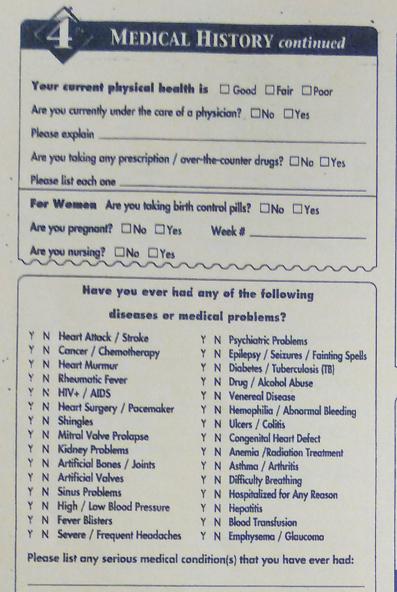


The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum

oral health. Please fill out these forms completely. The better we communicate, the better we can care for you.

The story

Today's Date:		Primary Dental Insurance
Name: UST PRST ME Nº ANS AS DE		Insurance Co. Name:
I prefer to be colled: Male Female		Insurance Co. Address:
Birthdate:/ Age: \$5 #:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Insurance Co. Phone #:
Home Address:		Group # (Plan, Local or Policy #):
API / CORDO S		Insured's Name: Relation:
□ Single □ Married □ Divorced □ Widowed □ Separated		Insured's Birthday: / / Insured's SS #:
Home #: Pager / Other #:		Insured's Employer:
WK #: Ext DL #:		Secondary Dental Insurance
Employer:		Insurance Co. Name:
Employer's Address:		Insurance Co. Address:
How long there? Occupation:	1	Insurance Co. Phone #:
Where & when are best times to reach you?	14	Group # (Plan, Local or Policy #):
Who may we Thank for referring you?	-	Insured's Name: Relation:
Other family members seen by us:	177	Insured's Birthday: / / Insured's SS #:
Previous / Present Dentist:	7	Insured's Employer:
Last Viels Date:		<u> </u>
A THE TANK T		In the event of an emergency, is there someone
2 Spouse Information		who lives near you that we should contact?
	200	Their Name: Relation:
Their Name:		WK#: HM#:
Employer:		
WK #:	-1	THE RESERVE THE PARTY OF THE PA
Birthdate: DL#:	1	Medical History
		Do you have a personal physician? No Yes
Person Responsible for Account:	12	Physician's Name:
WK#: Ext HM#:		Phone #: Date of last visit:
Billing Address:	1	Pure of real Yiell,
Relationship:SS #:	-	CONTINUED ON BACK O
Employer: DL 4:		



Are you allergic to any of the following drugs?

Y N Dental Anesthetics

Y N Tetracycline

Y N Codeine

Please list any other drugs that you are allergic to:

Y N Penicillin

Y N Erythromycin

Y N Aspirin

The second second second				
Do you like your smile?	No □Yes I	o your gums e	ver bleed?	lNo □Yes
How many times a week	do you floss?	a day	do you brush	n?
Type of bristles? □H	lard Med	ium   Soft		
	~~~	~~~	-	~~~
given	today is e. I also und he strictes orm this o othorize the ices with m	ffice of any dental staf y informed o	the best t this info e and it changes f to perfo	of my rmation is my in my orm any
Signature			Date	
Payment is also in I	ull at the Si	me of dream	cent wales	prior

Why have you come to the dentist today?

Have you ever had a serious / difficult problem associated with any

Do you now or have you ever experienced pain /

Your current dental health is Good Fair Poor

discomfort in your jaw joint (TMJ / TMD)? No Yes

Are you currently in pain? No Yes

previous dental work? No Yes



Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY					
I verbally reviewed the medical / dental information above with the patient named herein. Initials					
Doctor's Comments:					
MEDICAL HISTORY UPDATE					
1. Date	Comments	Signature			
2. Date	Comments	Signature			
3. Date		Signature 1000 INFORMS INC. 1 200 700 4884			

Y N Latex

Y N Other