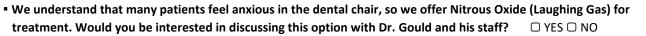


Personal Information

Patient First/Last Nam	e:		Preferred Name:			
DOB:	Gender:	SS#	Marital Status: Single Married Widowed			
Cell:		Home:	Work:			
Email:						
Address:			_ City, State:	Zip:		
Emerg Contact #:		Name:		Relation:		
*How did you hear ab	out us?					
		Dental Ins	urance			
Insurance Company:	Employer:					
Name of Insured:			DOB:	Relation to Patient:		
Insured SS #:		Member/Subscriber ID:				
Secondary Insurance:_		Employer:				
				Relation to Patient:		
	Member/Subscriber ID:					
	Ackno	wledgement of Receipt o	f Notice of Privac	y Practices		
		You may refuse to sign th	is acknowledgem	ent.		
I,			m aware that I ha	ve access to a copy of this office's Notice		
(Patient/Guardian	Name PRINTED,					
of Privacy Practices (p	rovided upon r	equest).				
X			-			
Patient/Guardian Si	gnature			Date		
		THIS SECTION FOR C	OFFICE USE ONL	Y		
	written acknow	ledgement of receipt of Noti	ce of Privacy Praction	ces, but acknowledgement could not be		
obtained because:Individual refused to s	sign.					
	-	taining the acknowledgeme	ent.			
	-	from obtaining acknowledge				
□ Other (Please specify)	:					

Dental/Health History





Reason(s) for your visit today:			
Previous Dentist:	Date of Last Dental Care / Xrays:		
• How often do you floss?	How often do you brush?		
 Mark (with an X) any of the following 	that you are having issues with presently:		
Bad Breath	Sensitivity to Cold	Stained/Discolored Teeth	
🗆 Loose Teeth	Sensitivity to Sweets	Crooked/Crowded Teeth	
Bleeding Gums	Sensitivity to Biting	Clicking/Popping Jaw	
Broken Fillings	Food Between Teeth	Grinding Teeth	
Sensitivity to Hot	Sores or Growths in Your Mouth	Periodontitis/Gum Diseas	
	Date of Last		
 Mark (with an X) any of the following 	for which you have ever been treated/conditio	ons that apply to you:	
🗆 Anemia	🗆 Diabetes - Type 🗆 1 🗆 2	Liver Disease	
□ Anxiety	Epilepsy/Seizures	Mitral Valve Prolapse	
Arthritis/Rheumatism	Fainting	Osteoporosis	
Artificial Heart Valve	Headaches/Migraines	Scarlet Fever	
Artificial Joint	Heart Problems	Stroke	
Asthma/Respiratory Problems	🗆 Hepatitis - Type 🗆 A 🗆 B 🗆 C	Thyroid Problems	
Blood Disease/Hemophilia	High or Low Blood Pressure	🗆 Tobacco Habit	
Cancer/Tumor		Tonsillitis	
Circulatory Problems	🗆 Jaw Pain/TMJ	Tuberculosis	
Cough, Persistent	C Kidney Disease	Venereal Disease	
-List any other serious illnesses, condition	ions, operations:		
Current Medications (if none, write N	ONE):		
 Have you ever taken medication for o 	steoporosis? 🗆 Yes 🗆 No If yes, please list:		
 Allergies (Mark with an X any that applied to the second se	ply):		
None Aspirin Barbiturates (Sleep)	oing Pills) 🗆 Codeine 🗆 Local Anesthesia 🗆 Peni	cillin 🗆 Sulfa 🗆 Latex	
□ Other:			
 Are you required to take antibiotic pr 	emedication for dental visits? OY ON If yes, for	what?	
*FOR WOMEN ONLY - Mark (with an X)	any that apply:		
□ Pregnant □ Nursing □ Taking birth co	ontrol pills 🗆 None of These		

Patient Name (Printed)

Χ_

Patient/Guardian signature