

## **PATIENT REGISTRATION - ADULT**

First Name		_			
Address (no P.O. boxes please)		_ City		State	_ Zip Code
Home Phone					
Email Address				Email: Y	or N
Date of Birth//	s	ocial Security	#	·• _	
Drivers License No					
Please Circle One: Married	Single	Divorced	Widowed		
Preferred Pharmacy		Ad	ddress:		
	DENTAL IN	ISURANCE II	NFORMATI	ON	
Primary Insurance					
nsurance Company Name:		In:	sured's Nam	e:	
nsurance Company Name:		In:	sured's Nam City/State	e: /Zip:	
nsurance Company Name: nsured's Address:/ nsured's Date of Birth:/_		Ins	sured's Nam City/State Social Securi	e: /Zip: ty #	
nsurance Company Name: nsured's Address:/ nsured's Date of Birth:/_ Employer		Insured's S _ Employer Add	sured's Nam City/State Social Securi ress	e: /Zip: ty #	
nsurance Company Name: nsured's Address: nsured's Date of Birth:/_ Employer Secondary Insurance nsurance Company Name:		Insured's S _ Employer Add	sured's Name City/State Social Securi ress	e: /Zip: ty # e:	
Primary Insurance Insurance Company Name: Insured's Address:/ Insured's Date of Birth:/ Employer  Secondary Insurance Insurance Company Name: Insured's Address:/ Insured's Date of Birth:/		Insured's S _ Employer Add	sured's Name City/State Social Securi ress sured's Name	e: /Zip: ty # e: te/Zip:	

## **OFFICE POLICIES**

Thank you for choosing our practice to serve your dental needs. Please take the time to read and initial each section and sign and date

the bottom of this form.	
Full payment is due at the time of service unless any treatment.	arrangements have been made prior to the start of
Insurance balances are ultimately the patient's obcost to you as a courtesy. However, insurance babilled to you. Please keep your walk-out statemer ensure prompt payment.	lances which are not paid within 60 days may be
Some of your treatment may <u>not</u> be covered by your will be your responsibility.	our insurance carrier. The cost for such charges
Major services may require a deposit equal to at lambda.	east one half of the estimated patient portion at the
Patients are asked to confirm their appointments our office or by responding to our confirmation co appointment may result in a \$50.00 charge for the	,
There will be a fee of \$30.00 for any checks retur	ned as Non-Sufficient Funds (NSF).
Patient balances that go unpaid for 90 days or mo  Interest charges for 1.5% per month  18% APR collection fees (up to 25% of the Legal fees for collection services	ore may incur one or more of the following charges: e full balance)
If you choose to pay with a credit or debit card, a balance. (HSA cards are exempt from the 3% fee	•
PHOTOGRAPHY	RELEASE
I, authorize Evan Hipp D of my face, jaws, and teeth. I understand that the photogra my care, and may be used for educational purposes in lect publication, newspapers, magazines, television), profession and/or social media (Facebook, etc.). I further understand to kept confidential. I do not expect compensation, financial of	ures, demonstrations, advertising (including website nal publications (dental magazines and journals, hat my name or other identifying information will be
ACKNOWLEDGMENT OF RECIEPT OF	NOTICE OF PRIVACY PRACTICES
I, have reviewed a large had full opportunity to read and consider the contents of this offic am giving permission to use and disclose my protected health information operations. I also understand that I have the right to revoke or modify the	on to use in treatment, payment activities, and healthcare
To give consent to disclose healthcare information t their name and relationship	
Name:Relationship to patient:	
Relationship to patient:	
Signature of Patient/Parent or Legal Guardian	Date

## **DENTAL HISTORY**

What is the reason for your visit tod	ay?				
What is the date of your last dental	visit?		Cleaning		X-rays
Previous Dentist's name:					
How often do you have dental exan	ninations?	·		····	
How often do you brush your teeth?	·		_ Floss?		
Do you have a dental problem now	? Yes		No		
If yes, please explain					
Are any of your teeth sensitive t	to:			Are you satisfie	ed with your teeth's appearance?
Hot or cold	Yes	No		Yes	No
Sweets	Yes	No			
Biting or chewing	Yes	No		Would you like Yes	to keep your teeth for a lifetime? No
Do you experience any of the fo	llowina:			Do you feel ner	vous about having dental work?
Mouth odors or bad taste	Yes	No		Yes	No
Frequent fever blisters	Yes	No			
Bleeding or hurting gums	Yes	No		If so, what is you	ır biggest concern?
Do you notice any loose teeth?	Yes	No			
Food getting caught between	Yes	No			
your teeth?					ad an upsetting dental
If so, where				experience?	
				If yes, please de	scribe:
Do you:					
Grind your teeth (awake/sleep)	Yes	No			
Bite your lips or cheeks regularly	Yes	No			
Mouth breathe (awake/sleep)	Yes	No			
Snore or have a sleep disorder	Yes	No		Is there anythin	ng else about dental treatment that
'				you would like	us to know?
Have you ever had:					
Orthodontic treatment	Yes	No			
Oral Surgery	Yes	No			
Periodontal treatment	Yes	No			
A bite plate or mouth guard	Yes	No			
,	100	110			
Have you experienced:	Voo	No			
Clicking or popping of the jaw	Yes	No No			
Pain (joint, ear, side of face)	Yes	No No			
Difficulty opening/closing Difficulty chewing on either side	Yes	No No			
, ,	Yes	No No			
Headaches, neck aches	Yes	No			
Sore muscles	Yes	No			

Patient Signature \_\_\_\_\_ Date \_\_\_\_

## **MEDICAL HISTORY**

HIV positive Yes No Diabetes Yes No Herpes Yes No Rheumatic Fever Yes No Alzheimer's Disease Yes No Drug Addiction Yes No High Blood Pressure Yes No Shingles Yes No Angina Yes No Easily Winded Yes No High Cholesterol Yes No Sickle Cell Disease Yes No Angina Yes No Emphysema Yes No High Cholesterol Yes No Sickle Cell Disease Yes No Angina Yes No Emphysema Yes No Hives or Rash Yes No Sinus Trouble Yes No Artificial Heart Valve Yes No Excessive Bleeding Yes No Hives or Rash Yes No Sinus Trouble Yes No Artificial Joints Yes No Excessive Bleeding Yes No Kidney Problems Yes No Stomach Disease Yes No Asthma Yes No Excessive Thirst Yes No Kidney Problems Yes No Stomach Disease Yes No Blood Disease Yes No Frequent Cough Yes No Liver Disease Yes No Blood Transfusion Yes No Frequent Cough Yes No Low Blood Pressure Yes No Thyroid Disease Yes No Braise Easily Yes No Glaucoma Yes No Mitral Valve Prolapse Yes No Cancer Yes No Hay Fever Yes No Heart Attack/Failure Yes No Parithyroid Disease Yes No Congenital Herpey Yes No Heart Murmur Yes No Parathyroid Disease Yes No Congenital Heart Disease Yes No Heart Trouble/Disease Yes No Radiation Treatment Yes N	Patient Name:					/Birth Date:/							
Have you ever been hospitalized or had a major operation? Yes No Have you ever had a serious head or neck injury?  Are you taking any medications, pills, or drugs?  Yes No If yes, please ist medications:  If yes, please list medications:  If yes, please explain:  If yes, pl				n that you may be tak	ing, co	uld ha	ive a	n important interrelation					
Have you ever had a serious head or neck injury?  Are you taking any medications, pills, or drugs?  Yes No If yes, please list medications:  If yes, please explain:  If yes, please explain	Are you under a physi	cian's ca	re now	?	Yes	No	N	ame of Family Physicia	n:				
Are you taking any medications, pills, or drugs?  Have you ever taken Phen-Fen or Redux?  Have you ever taken Phen-Fen or Redux?  Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Are you aware of any allergic (or adverse) reaction to any medication or substance?  Are you as a special diel?  Do you use tobacco?  WOMEN: Are you or a special diel?  Do you use tobacco?  Are you on a special diel?  Are you allergic to any of the following?  Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs  Other If yes, please explain:  Do you have, or have you had, any of the following?  Al.D.S. Two No Diabetes  Other Wower of the yes No Diabetes  Arbeimer's Diease Yes No Diabetes  Yes No High Blood Pressure Yes No Shingles  Anglina Yes No Easily Winded Yes No High Slood Pressure Yes No Anglina Yes No Easily Winded Yes No High Slood Pressure Yes No Anglina Yes No Epilepsy or Selection Yes No High Slood Pressure Yes No Anglina Yes No Epilepsy or Selection Yes No High Slood Pressure Yes No Anglina Yes No Epilepsy or Selection Yes No High Slood Pressure Yes No Shingles Yes No Anthitisch Heart Valve Arbeimer's Diease Yes No Epilepsy or Selection Yes No High Slood Pressure Yes No Shingles Yes No Anthitisch Heart Valve Arbeimer's Diease Yes No High Slood Pressure Yes No Sciula Trouble Yes No High Slood Pressure Yes No Shingles Yes No High Slood Pressure Yes No No High Slood Pressure Yes No No High Slood Pressure	Have you ever been h	ospitalize	ed or ha	ad a major operation?	Yes	No	lf	yes, please explain:					
Have you ever taken Phen-Fen or Redux? Yes No If yes, please list medications:  Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Are you aware of any allergic (or adverse) reaction to any medication or substance?  Are you or an apscial diel?  Do you use tobacco?  WOMEN: Are you pregnant/trying to get pregnant? Yor N  Are you allergic to any of the following?  Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs  Other If yes, please explain:  Do you have, or have you had, any of the following?  AlD.S Yes No Disbetes Yes No Herpes No Herpes No Rheumatic Fever Yes No Alzemenr's Disease Yes No Drug Addiction Yes No High Cholesterol Yes No Rheumatic Fever Yes No Alzemenr's Disease Yes No Emphysema circums Yes No High Cholesterol Yes No Shingles Yes No Argina Yes No Emphysema circums Yes No High Cholesterol Yes No Sinus Trouble Yes No Afficial Joints Yes No Excessive Thirst Yes No Kathema Yes No Excessive Thirst Yes No Kathema Yes No Excessive Thirst Yes No Kathema Yes No Excessive Thirst Yes No Herpess Yes No Kathema Yes No Excessive Thirst Yes No Hold Trouble Provided Disease Yes No Kathema Yes No Excessive Thirst Yes No Kathema Yes No Excessive Thirst Yes No Kathema Yes No Genital Herpes Yes No Low Blood Pressure Yes No Hold Disease Yes No Hold D	Have you ever had a s	serious he	ead or	neck injury?	Yes	No	If	yes, please explain:					
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Are you aware of any allergic (or adverse) reaction to any medication or substance?  Are you as pecial diet?  Are you use tobacco?  WOMEN: Are you pregnant/trying to get pregnant? Y or N  Are you allergic to any of the following?  Are you allergic to any of the following?  Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs  Other If yes, please explain:  Do you have, or have you had, any of the following?  Al I.D.S  Al I.D.S  Achiemer's Disease Yes No Diabetes  Alzheimer's Disease Yes No Diabetes  Arbinided Hand Yes No Easily Winded Yes No High Blood Pressure Yes No Shingles  Arbinided Hant Valve Yes No Epilepsy or Seizures Yes No High Blood Pressure Yes No Sinciples  Arthritis/Cout Yes No Epilepsy or Seizures Yes No High Blood Pressure Yes No Sinciples  Arthritis/Cout Yes No Excessive Bleeding Yes No High Blood Pressure Yes No Sinciples  Arthritis/Cout Yes No Excessive Blinding Yes No Excessive Printing Or Dizzy Spells Yes No International Yes No Stonke Yes No Rathman Yes No Excessive Blinding Yes No Excessive Printing Or Dizzy Spells Yes No Loude Disease Yes No Thyroid Disease Yes No Rathman Yes No Genital Herpes Yes No Loude Directory Yes No Genital Herpes Yes No Loude Directory Yes No Genital Herpes Yes No Loude Directory Yes No Hay Fever No Hay Fever Yes No Rathman Yes No Genital Herpes Yes No Loude Directory Yes No Hay Fever Yes No Rathman Yes No Genital Herpes Yes No Loude Directory Yes No Hay Fever Yes No Rathman Yes No Genital Herpes Yes No Loude Directory Yes No Hay Fever Yes No Rathman Yes No Genital Herpes Yes No Loude Directory Yes No Hay Fever No Hay Fever Yes No Rathman Yes No Hay Fever Yes No Hay Fever Yes No Rathman Yes No Hay Fever Yes No Hay Fever Yes No Hay Fever Y	Are you taking any me	Are you taking any medications, pills, or drugs?				No	If	yes, please list medicat	tions:				
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Are you aware of any allergic (or adverse) reaction to any medication or substance?  Are you as pecial diet?  Are you use tobacco?  WOMEN: Are you pregnant/trying to get pregnant? Y or N  Are you allergic to any of the following?  Are you allergic to any of the following?  Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs  Other If yes, please explain:  Do you have, or have you had, any of the following?  Al I.D.S  Al I.D.S  Achiemer's Disease Yes No Diabetes  Alzheimer's Disease Yes No Diabetes  Arbinided Hand Yes No Easily Winded Yes No High Blood Pressure Yes No Shingles  Arbinided Hant Valve Yes No Epilepsy or Seizures Yes No High Blood Pressure Yes No Sinciples  Arthritis/Cout Yes No Epilepsy or Seizures Yes No High Blood Pressure Yes No Sinciples  Arthritis/Cout Yes No Excessive Bleeding Yes No High Blood Pressure Yes No Sinciples  Arthritis/Cout Yes No Excessive Blinding Yes No Excessive Printing Or Dizzy Spells Yes No International Yes No Stonke Yes No Rathman Yes No Excessive Blinding Yes No Excessive Printing Or Dizzy Spells Yes No Loude Disease Yes No Thyroid Disease Yes No Rathman Yes No Genital Herpes Yes No Loude Directory Yes No Genital Herpes Yes No Loude Directory Yes No Genital Herpes Yes No Loude Directory Yes No Hay Fever No Hay Fever Yes No Rathman Yes No Genital Herpes Yes No Loude Directory Yes No Hay Fever Yes No Rathman Yes No Genital Herpes Yes No Loude Directory Yes No Hay Fever Yes No Rathman Yes No Genital Herpes Yes No Loude Directory Yes No Hay Fever Yes No Rathman Yes No Genital Herpes Yes No Loude Directory Yes No Hay Fever No Hay Fever Yes No Rathman Yes No Hay Fever Yes No Hay Fever Yes No Rathman Yes No Hay Fever Yes No Hay Fever Yes No Hay Fever Y	Have you ever taken F	Phen-Fen	or Re	dux?	Yes	No	If	ves, please list medical	tions:				
Are you aware of any allergic (or adverse) reaction to any medication or substance?  Are you on a special diet?  Do you use tobacco?  WOMEN: Are you pregnant/trying to get pregnant? Y or N  Are you allergic to any of the following?  Are you allergic to any of the following?  Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs  Other If yes, please explain:  Do you have, or have you had, any of the following?  ALID.S Yes No Cortsone Medication Yes No Herpes Yes No Rheumatic Fever Yes No Herpes Yes No Rheumatic Fever Yes No Alphinger's Disease Yes No Lasily Winded Yes No High Cholesterol Yes No Sickle Cell Disease Yes No Arthritis/Cout Yes No Epilopsy or Seizures Yes No Hypoglycemia Yes No Sinka Birdia Yes No Arthritis/Cout Yes No Excessive Bleeding Yes No Hypoglycemia Yes No Sinka Drugs Wes No Arthritis/Cout Yes No Excessive Thirst Yes No International Yes No Encland Disease Yes No High Cholesterol Yes No Sinka Drugs Wes No Arthritis/Cout Yes No Excessive Thirst Yes No International Yes No Excessive Thirst Yes No International Yes No Encland Drugs Yes No Blood Transfusion Yes No Frequent Cough Yes No Holes Presume Yes No Stroke Yes No Stroke Yes No Remain Yes No Encland Yes No Hypoglycemia Yes No Stroke Yes No Hypoglycem	·												
Are you on a special diet?  Are you use tobacco?  WOMEN: Are you pregnant/trying to get pregnant? Y or N  Are you allergic to any of the following?  Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs  Other If yes, please explain:  Do you have, or have you had, any of the following?  ALID.S Yes No Diabetes Yes No Diabetes Yes No Herpes Yes No Renal Dialysis Yes No Hilly Positive Yes No Easily Winded Yes No High Blood Pressure Yes No Shingles Yes No Arthritis/Gout Arthritis/Gout Yes No Excessive Bleeding Yes No Irrequiar Heartbeat Yes No Excessive Bleeding Yes No Irrequiar Heartbeat Yes No Entantian Yes No Frequent Dough Yes No Illodd Yes No Irrequiar Heartbeat Yes No Solinable Yes No Blood Dressure Yes No Solinable Yes No High Blood Pressure Yes No Stringles Yes No Arthritis/Gout Arthritis/Gout Yes No Excessive Bleeding Yes No Irrequiar Heartbeat Yes No Stronder Yes No Entantian Yes No Frequent Dough Yes No Irrequiar Heartbeat Yes No Stronder Yes No Ellood Dressure Yes No Hoppide Pressure Yes No Stronder Yes No Entantian Yes No Frequent Dough Yes No Loweshier Problems Yes No Glaucoma Yes No Low Blood Pressure Yes No Tonsillitis Yes No Entanting Problems Yes No Glaucoma Yes No Low Blood Pressure Yes No Tonsillitis Yes No Entanting Problems Yes No Heart Matack/Failure Yes No Pain in Jay Joints Yes No Congenital Heart Yes No Heart Matack/Failure Yes No Pain in Jay Joints Yes No Congenital Heart Yes No Heart Matack/Failure Yes No Pain in Jay Joints Yes No Congenital Heart Yes No Heart Matack/Failure Yes No Pain in Jay Joints Yes No Congenital Heart Disease Yes No Heart Matack/Failure Yes No Pain in Jay Joints Yes No Congenital Heart Yes No Heart Matack/Failure Yes No Pain in Jay Joints Yes No Congenital Heart Yes No Heart Matack/Failure Yes No Pain in Jay Joints Yes No Congenital Heart Yes No Heart Matack/Failure Yes No Pain in Jay Joints Yes No Congenital Heart Disease Yes No Heart Matack/Failure Yes No Pain in Jay Joints Yes No Congenital Heart Disease Yes No Heart Matack/Failure Yes No	other medications con	taining bi	sphosp	phonates?	Yes	No		yes, please list medical	tions:				
WOMEN: Are you pregnant/trying to get pregnant? Yor N  Are you allergic to any of the following?  Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs Other If yes, please explain:  Do you have, or have you had, any of the following?  A.I.D.S Yes No Cortisone Medication Yes No Hepatitis A, B, C Yes No Renal Dialysis Yes No HIV positive Yes No Diabetes Yes No High Blood Pressure Yes No Shingles Yes No Anemia Yes No Easily Winded Yes No High Cholesterol Yes No High School Sickle Cell Disease Yes No Arthritis/Gout Yes No Hilly positive Yes No Excessive Bleeding Yes No Hiregular Heartheat Yes No Simus Trouble Yes No Arthritis/Gout Yes No Hiregular Heartheat Yes No Simus Trouble Yes No Arthritis/Gout Yes No Hiregular Heartheat Yes No Simus Trouble Yes No Hiregular Heartheat Yes No Simus Yes No Trouble Yes No Hiregular Heartheat Yes No Simus Yes No Trouble Yes No Hiregular Heartheat Yes No Hiregular Heartheat Yes No Hiregular Heartheat Yes No Hiregular Heart			or adve	erse) reaction to any	Yes	No	If	yes, please explain:					
WOMEN: Are you pregnant/trying to get pregnant? Y or N  Are you allergic to any of the following?  Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs  Other If yes, please explain:    Do you have, or have you had, any of the following?  A.I.D.S Yes No Cortisone Medication Yes No Hepatitis A, B, C Yes No Rheumatic Fever Yes No Alzheimer's Disease Yes No Drug Addiction Yes No High Blood Pressure Yes No Slickle Cell Disease Yes No Anemia Yes No Easily Winded Yes No High Cholesterol Yes No Slickle Cell Disease Yes No Artificial Joints Yes No Excessive Bleeding Yes No Hregular Heartbeat Yes No Stomach Disease Yes No Artificial Joints Yes No Excessive Thirst Yes No Kidney Problems Yes No Stomach Disease Yes No Blood Transfusion Yes No Genital Herpes Yes No Low Broething Problems Yes No Galaucoma Yes No Galaucoma Yes No Low Broething Problems Yes No Galaucoma Yes No Hart Murmur Yes No Cancer Yes No Heart Murmur Yes No Cancer Yes No Heart Murmur Yes No Congenital Heart Disease Yes No Heart Murmur Yes No Congenital Heart Disease Yes No Heart Murmur Yes No Radiation Treatment Yes No Congenital Heart Disease Yes No Heart Murmur Yes No Radiation Treatment Yes No Congenital Heart Disease Yes No Heart Murmur Yes No Radiation Treatment Yes No Congenital Heart Disease Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No Yes No Congenital Heart Disease Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No Congenital Heart Disease, Yes No Heart Trouble/Disease, Yes No Recent Weight Loss Yes No Yes No Congenital Heart Disease, Yes No Heart Trouble/Disease, Yes No Recent Weight Loss Yes No Yes No Congenital Heart Disease, Yes No Heart Trouble/Disease, Yes No Recent Weight Loss Yes No Yes No Congenital Heart Disease, Yes No Heart Trouble/Disease, Yes No Recent Weight Loss Yes No Yes No Congenital Heart Disease, Yes No Heart Trouble/Disease, Yes No Recent Weight Loss Yes No Yes No Congenital Heart Disease, Yes No Heart Trouble/Disease, Yes No Recent Weight Loss Yes No Yes No Congenital Hear	Are you on a special o	liet?			Yes	No	lf	yes, please explain:					
Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs  Other If yes, please explain:    Do you have, or have you had, any of the following?   ALDS Yes No Cortisone Medication Yes No Hepatitis A, B, C Yes No Renal Dialysis Yes No HIV positive Yes No Diabetes Yes No Herpes Yes No Sickle Cell Disease Yes No Alzheimer's Disease Yes No Drug Addiction Yes No High Cholesterol Yes No Sickle Cell Disease Yes No Arthritis/Gout Yes No Epilepsy or Seizures Yes No Hypoglycemia Yes No Sickle Cell Disease Yes No Arthritis/Gout Yes No Excessive Bleeding Yes No Hypoglycemia Yes No Stomach Disease Yes No Artificial Joints Yes No Frequent Cough Yes No Liver Disease Yes No Stomach Disease Yes No Asthma Yes No Frequent Cough Yes No Liver Disease Yes No Liver Disease Yes No Stomach Disease Yes No Blood Disease Yes No Liver Disease Yes No Liver Disease Yes No Tonsillitis Yes No Requent Yes No Genital Herpes Yes No Lung Disease Yes No Tonsillitis Yes No Cancer Yes No Gealtal Herpes Yes No Mitral Valve Prolapse Yes No Tumors or Growths Yes No Cancer Yes No Hay Fever Yes No Reath Wes No Heart Attack/Failure Yes No Deart Murmur Yes No Pain In Jaw Joints Yes No Convolvations Yes No Heart Attack/Failure Yes No Pain In Jaw Joints Yes No Convolvations Yes No Heart Attack/Failure Yes No Recent Weight Loss Yes No Tumors or Growths Yes No Convolvations Yes No Heart Attack/Failure Yes No Recent Weight Loss Yes No Tonsillitis Yes No Convolvations Yes No Heart Murmur Yes No Recent Weight Loss Yes No Tonsillitis Yes No Convolvations Yes No Heart Murmur Yes No Recent Weight Loss Yes No Tonsillitis Yes No Convolvations Yes No Heart Murmur Yes No Recent Weight Loss Yes No Tonsillitis Yes No Convolvations Yes No Heart Murmur Yes No Recent Weight Loss Yes No Tonsillitis Yes No Convolvations Yes No Heart Murmur Yes No Recent Weight Loss Yes No Tonsillitis Yes No Convolvations Yes No Heart Murmur Yes No Recent Weight Loss Yes No No Near Metal Toroble/Disease Yes No Recent Weight Loss Yes No Heart Steam No Heart Murmur Yes No Recent	Do you use tobacco?				Yes	No							
Other If yes, please explain:    Do you have, or have you had, any of the following?	, ,	,		0 1 0			ıaı	king Oral Contraceptive	S? Y C	or N	Nursing? Y	or N	
Do you have, or have you had, any of the following?  A.I.D.S. Yes No Cortisone Medication Yes No Hepatitis A, B, C Yes No Renal Dialysis Yes No HIJO Diabetes Yes No Herpes Yes No Herpes Yes No Renal Dialysis Yes No Alzheimer's Disease Yes No Drug Addiction Yes No High Blood Pressure Yes No Sickle Cell Disease Yes No Angina Yes No Emphysema Yes No High Cholesterol Yes No Sickle Cell Disease Yes No Arthritis/Gout Yes No Epilepsy or Seizures Yes No Hypoglycemia Yes No Sickle Cell Disease Yes No Arthritis/Gout Yes No Excessive Bleeding Yes No Hypoglycemia Yes No Sickle Cell Disease Yes No Arthritis/Gout Yes No Excessive Bleeding Yes No Hypoglycemia Yes No Sickle Cell Disease Yes No Arthritis/Gout Yes No Excessive Bleeding Yes No Hypoglycemia Yes No Spina Bifida Yes No Arthritis/Gout Yes No Excessive Bleeding Yes No Irregular Heartbeat Yes No Stomach Disease Yes No Arthritis/Gout Yes No Excessive Bleeding Yes No Irregular Heartbeat Yes No Stomach Disease Yes No Arthritis/Gout Yes No Excessive Thirst Yes No Italience Yes No Swelling of Limbs Yes No Blood Disease Yes No Frequent Cough Yes No Leukemia Yes No Swelling of Limbs Yes No Breathing Problems Yes No Genital Herpes Yes No Lung Disease Yes No Tonsillitis Yes No Genital Herpes Yes No Lung Disease Yes No Tonsillitis Yes No Chemotherapy Yes No Genital Herpes Yes No Destending Yes No Pain In Jaw Joints Yes No Tonsillitis Yes No Chest Pain Yes No Heart Attack/Failure Yes No Payenitaric Care Yes No Heart Attack/Failure Yes No Payenitaric Care Yes No Congenital Heart Disease Yes No Heart Trouble/Disease Yes No Payenitaric Care Yes No Heart Trouble/Disease Yes No Payenitaric Care Yes No Congenital Heart Disease Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No Yenereal Disease Yes No Conditions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No Yenereal Disease Yes No Yenereal Disea	Aspirin	Penicillin	า	Codeine Loca	I Anes	thetics		Acrylic Metal		L	atex Sulfa Dr	ugs	
A.I.D.S Yes No Cortisone Medication Yes No Hepatitis A, B, C Yes No Renal Dialysis Yes No Alzheimer's Disease Yes No Diabetes Yes No Herpes Yes No High Blood Pressure Yes No Shingles Yes No Anemia Yes No Drug Addiction Yes No High Blood Pressure Yes No Shingles Yes No Angina Yes No Easily Winded Yes No High Cholesterol Yes No Sickle Cell Disease Yes No Arthritis/Gout Yes No Epilepsy or Seizures Yes No Hives or Rash Yes No Sinus Trouble Yes No Arthritis/Gout Yes No Epilepsy or Seizures Yes No Hypoglycemia Yes No Spina Bifida Yes No Artificial Heart Valve Yes No Excessive Bleeding Yes No Inregular Heartbeat Yes No Storach Disease Yes No Asthma Yes No Excessive Thirst Yes No Kidney Problems Yes No Storach Disease Yes No Asthma Yes No Frequent Cough Yes No Leukemia Yes No Swelling of Limbs Yes No Blood Disease Yes No Frequent Cough Yes No Liver Disease Yes No Thyroid Disease Yes No Bruise Easily Yes No Ganital Herpes Yes No Ganital Herpes Yes No Ganital Herpes Yes No Mitral Valve Problems Yes No Ganital Herpes Yes No Mitral Valve Prolapse Yes No Cancer Yes No Heart Attack/Failure Yes No Osteoporosis Yes No Costeoporosis Yes No Costeoporosis Yes No Heart Attack/Failure Yes No Recent Weight Loss Yes No Cond Sore/Fever Blister Yes No Heart Attack/Failure Yes No Recent Weight Loss Yes No Cond Sore/Fever Blister Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No Trouble/Disease Information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.	Other	If yes,	please	e explain:									
A.I.D.S Yes No Cortisone Medication Yes No Hepatitis A, B, C Yes No Renal Dialysis Yes No Alzheimer's Disease Yes No Diabetes Yes No Herpes Yes No High Blood Pressure Yes No Shingles Yes No Anemia Yes No Drug Addiction Yes No High Blood Pressure Yes No Shingles Yes No Angina Yes No Easily Winded Yes No High Cholesterol Yes No Sickle Cell Disease Yes No Arthritis/Gout Yes No Epilepsy or Seizures Yes No Hives or Rash Yes No Sinus Trouble Yes No Arthritis/Gout Yes No Epilepsy or Seizures Yes No Hypoglycemia Yes No Spina Bifida Yes No Artificial Heart Valve Yes No Excessive Bleeding Yes No Inregular Heartbeat Yes No Storach Disease Yes No Asthma Yes No Excessive Thirst Yes No Kidney Problems Yes No Storach Disease Yes No Asthma Yes No Frequent Cough Yes No Leukemia Yes No Swelling of Limbs Yes No Blood Disease Yes No Frequent Cough Yes No Liver Disease Yes No Thyroid Disease Yes No Bruise Easily Yes No Ganital Herpes Yes No Ganital Herpes Yes No Ganital Herpes Yes No Mitral Valve Problems Yes No Ganital Herpes Yes No Mitral Valve Prolapse Yes No Cancer Yes No Heart Attack/Failure Yes No Osteoporosis Yes No Costeoporosis Yes No Costeoporosis Yes No Heart Attack/Failure Yes No Recent Weight Loss Yes No Cond Sore/Fever Blister Yes No Heart Attack/Failure Yes No Recent Weight Loss Yes No Cond Sore/Fever Blister Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No Trouble/Disease Information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.	Do you have, or have yo	u had, an	y of th	e following?									
Alzheimer's Disease Yes No Drug Addiction Yes No High Blood Pressure Yes No Singles Yes No Anemia Yes No Easily Winded Yes No High Cholesterol Yes No Sickle Cell Disease Yes No Angina Yes No Epilepsy or Seizures Yes No Hives or Rash Yes No Sinus Trouble Yes No Arthritis/Gout Yes No Epilepsy or Seizures Yes No Hives or Rash Yes No Sinus Trouble Yes No Arthritis/Gout Yes No Excessive Bleeding Yes No Irregular Heartbeat Yes No Stroke Yes No Artificial Joints Yes No Excessive Bleeding Yes No Kidney Problems Yes No Stroke Yes No Asthma Yes No Fainting or Dizzy Spells Yes No Leukemia Yes No Stroke Yes No Blood Disease Yes No Frequent Cough Yes No Low Blood Pressure Yes No Thyroid Disease Yes No Breathing Problems Yes No Genital Herpes Yes No Lung Disease Yes No Tronsillitis Yes No Gancer Yes No Glaucoma Yes No Lung Disease Yes No Tuberculosis Yes No Chemotherapy Yes No Hay Fever Yes No Deart Mutral Valve Prolapse Yes No Uclers Yes No Chest Pain Yes No Heart Murmur Yes No Parathyroid Disease Yes No Congenital Heart Disease Yes No Heart Trouble/Disease Yes No Radiation Treatment Yes No Radiation Treatment Yes No Parathyroid Disease Yes No Convulsions Yes No Heart Pacemaker Yes No Radiation Treatment Yes No Radiation Treatment Yes No Parathyroid Disease Yes No Convulsions Yes No Heart Pacemaker Yes No Recent Weight Loss Yes No To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.	A.I.D.S	Yes	No	Cortisone Medication									No
Anemia Yes No Easily Winded Yes No High Cholesterol Yes No Sickle Cell Disease Yes No Angina Yes No Emphysema Yes No Hives or Rash Yes No Sinus Trouble Yes No Arthritis/Gout Yes No Epilepsy or Seizures Yes No Hypoglycemia Yes No Spina Bifida Yes No Arthritis/Gout Yes No Excessive Bleeding Yes No Irregular Heartbeat Yes No Stomach Disease Yes No Artificial Joints Yes No Excessive Bleeding Yes No Irregular Heartbeat Yes No Stomach Disease Yes No Artificial Joints Yes No Excessive Thirst Yes No Irregular Heartbeat Yes No Stomach Disease Yes No Asthma Yes No Excessive Thirst Yes No Leukemia Yes No Swelling of Limbs Yes No Blood Disease Yes No Frequent Cough Yes No Liver Disease Yes No Thyroid Disease Yes No Blood Transfusion Yes No Frequent Diarrhea Yes No Low Blood Pressure Yes No Tonsillitis Yes No Bruise Easily Yes No Galaucoma Yes No Mitral Valve Prolapse Yes No Tumors or Growths Yes No Cancer Yes No Hay Fever Yes No Mitral Valve Prolapse Yes No Tumors or Growths Yes No Chest Pain Yes No Heart Attack/Failure Yes No Pain in Jaw Joints Yes No Congenital Heart Disease Yes No Heart Trouble/Disease Yes No Radiation Treatment Yes No Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.													No
Angina Yes No Emphysema Yes No Hives or Rash Yes No Sinus Trouble Yes No Arthritis/Gout Yes No Epilepsy or Seizures Yes No Hypoglycemia Yes No Spina Biffida Yes No Artificial Heart Valve Yes No Excessive Bleeding Yes No Irregular Heartbeat Yes No Stomach Disease Yes No Artificial Joints Yes No Excessive Thirst Yes No Kidney Problems Yes No Stroke Yes No Asthma Yes No Fainting or Dizzy Spells Yes No Leukemia Yes No Swelling of Limbs Yes No Blood Disease Yes No Frequent Cough Yes No Liver Disease Yes No Thyroid Disease Yes No Breathing Problems Yes No Genital Herpes Yes No Low Blood Pressure Yes No Tonsillitis Yes No Bruise Easily Yes No Galaucoma Yes No Mitral Valve Prolapse Yes No Tuberculosis Yes No Cancer Yes No Hay Fever Yes No Osteoporosis Yes No Ulcers Yes No Chemotherapy Yes No Heart Murmur Yes No Pain in Jaw Joints Yes No Venereal Disease Yes No Conyulsions Yes No Heart Pacemaker Yes No Radiation Treatment Yes No Recent Weight Loss Yes No To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.													
Arthritis/Gout Yes No Epilepsy or Seizures Yes No Hypoglycemia Yes No Spina Bifida Yes No Artificial Heart Valve Yes No Excessive Bleeding Yes No Kidney Problems Yes No Stomach Disease Yes No Artificial Joints Yes No Fainting or Dizzy Spells Yes No Leukemia Yes No Stownach Disease Yes No Asthma Yes No Fainting or Dizzy Spells Yes No Leukemia Yes No Swelling of Limbs Yes No Blood Disease Yes No Frequent Cough Yes No Low Blood Pressure Yes No Thyroid Disease Yes No Breathing Problems Yes No Genital Herpes Yes No Lung Disease Yes No Tonsillitis Yes No Bruise Easily Yes No Glaucoma Yes No Mitral Valve Prolapse Yes No Cancer Yes No Heart Attack/Failure Yes No Pain in Jaw Joints Yes No Chemotherapy Yes No Heart Murmur Yes No Parathyroid Disease Yes No Cold Sore/Fever Blister Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No Convulsions Yes No Hemphilia Yes No Recent Weight Loss Yes No								, ,					
Artificial Joints Yes No Excessive Thirst Yes No Kidney Problems Yes No Stroke Yes No Asthma Yes No Fainting or Dizzy Spells Yes No Leukemia Yes No Swelling of Limbs Yes No Blood Disease Yes No Frequent Cough Yes No Low Blood Pressure Yes No Thyroid Disease Yes No Blood Transfusion Yes No Frequent Diarrhea Yes No Low Blood Pressure Yes No Tonsillitis Yes No Breathing Problems Yes No Genital Herpes Yes No Lung Disease Yes No Tuberculosis Yes No Bruise Easily Yes No Glaucoma Yes No Mitral Valve Prolapse Yes No Tuberculosis Yes No Cancer Yes No Hay Fever Yes No Osteoporosis Yes No Ulcres Yes No Chemotherapy Yes No Heart Attack/Failure Yes No Pain in Jaw Joints Yes No Venereal Disease Yes No Cold Sore/Fever Blister Yes No Heart Pacemaker Yes No Radiation Treatment Yes No Heart Disease Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No Tothe Dest of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.				1 '									No
Asthma Yes No Fainting or Dizzy Spells Yes No Leukemia Yes No Swelling of Limbs Yes No Blood Disease Yes No Frequent Cough Yes No Liver Disease Yes No Thyroid Disease Yes No Blood Transfusion Yes No Frequent Diarrhea Yes No Low Blood Pressure Yes No Tonsillitis Yes No Breathing Problems Yes No Genital Herpes Yes No Lung Disease Yes No Tuberculosis Yes No Bruise Easily Yes No Glaucoma Yes No Mitral Valve Prolapse Yes No Tuberculosis Yes No Cancer Yes No Hay Fever Yes No Osteoporosis Yes No Ulcers Yes No Chemotherapy Yes No Heart Attack/Failure Yes No Parathyroid Disease Yes No Venereal Disease Yes No Cold Sore/Fever Blister Yes No Heart Murmur Yes No Parathyroid Disease Yes No Congenital Heart Disease Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No Doyou now have or have you had any disease, condition, or problem not listed above? Yer No If yes, please list:  To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.													No
Blood Disease Yes No Frequent Cough Yes No Low Blood Pressure Yes No Tonsilitis Yes No Blood Transfusion Yes No Frequent Diarrhea Yes No Low Blood Pressure Yes No Tonsilitis Yes No Breathing Problems Yes No Genital Herpes Yes No Low Blood Pressure Yes No Tonsilitis Yes No Bruise Easily Yes No Genital Herpes Yes No Mitral Valve Prolapse Yes No Tumors or Growths Yes No Cancer Yes No Hay Fever Yes No Osteoporosis Yes No Ulcers Yes No Chemotherapy Yes No Heart Attack/Failure Yes No Pain in Jaw Joints Yes No Venereal Disease Yes No Cod Sore/Fever Blister Yes No Heart Murmur Yes No Partinic Care Yes No Conyculsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No Readiation Can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.				1							1		No
Blood Transfusion Yes No Frequent Diarrhea Yes No Low Blood Pressure Yes No Tourillitis Yes No Breathing Problems Yes No Genital Herpes Yes No Lung Disease Yes No Tuberculosis Yes No Bruise Easily Yes No Glaucoma Yes No Mitral Valve Prolapse Yes No Tuberculosis Yes No Cancer Yes No Hay Fever Yes No Osteoporosis Yes No Ulcers Yes No Chemotherapy Yes No Heart Attack/Failure Yes No Pain in Jaw Joints Yes No Venereal Disease Yes No Cold Sore/Fever Blister Yes No Heart Murmur Yes No Parathyroid Disease Yes No Congenital Heart Disease Yes No Heart Trouble/Disease Yes No Radiation Treatment Yes No Recent Weight Loss Yes No If yes, please list:  To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.													
Breathing Problems Yes No Genital Herpes Yes No Bruise Easily Yes No Glaucoma Yes No Mitral Valve Prolapse Yes No Tumors or Growths Yes No Cancer Yes No Hay Fever Yes No Osteoporosis Yes No Ulcers Yes No Chemotherapy Yes No Heart Attack/Failure Yes No Pain in Jaw Joints Yes No Venereal Disease Yes No Cold Sore/Fever Blister Yes No Heart Pacemaker Yes No Parathyroid Disease Yes No Yellow Jaundice Yes No Convulsions Yes No Heart Trouble/Disease Yes No Radiation Treatment Yes No Recent Weight Loss Yes No If yes, please list:  To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.	E .												
Bruise Easily Yes No Glaucoma Yes No Mitral Valve Prolapse Yes No Ucancer Yes No Hay Fever Yes No Osteoporosis Yes No Ucers Yes No Osteoporosis Yes No Ucers Yes No Osteoporosis Yes No Venereal Disease Yes No Venereal Disease Yes No Consequent Disease Yes No Parathyroid Disease Yes No Parath	l .							1					
Cancer Yes No Hay Fever Yes No Osteoporosis Yes No Ulcers Yes No Chemotherapy Yes No Heart Attack/Failure Yes No Pain in Jaw Joints Yes No Venereal Disease Yes No Chest Pain Yes No Heart Murmur Yes No Parathyroid Disease Yes No Yellow Jaundice Yes No Congenital Heart Disease Yes No Heart Trouble/Disease Yes No Radiation Treatment Yes No Convulsions Yes No Hemophilia Yes No Recent Weight Loss Yes No If yes, please list:  To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.													No
Chest Pain Yes No Heart Murmur Yes No Cold Sore/Fever Blister Yes No Heart Pacemaker Yes No Congenital Heart Disease Yes No Heart Trouble/Disease Yes No Hemophilia Yes No Recent Weight Loss Yes No Rec		Yes			١	/es	No			No	Ulcers	Yes	No
Cold Sore/Fever Blister Yes No Congenital Heart Disease Yes No Heart Trouble/Disease Yes No Hemophilia Yes No Recent Weight Loss Yes No Recent Weigh													No
Congenital Heart Disease Yes No Yes No Hemophilia Yes No Recent Weight Loss Yes No Recent Weight	1										Yellow Jaundice	Yes	No
Do you now have or have you had any disease, condition, or problem not listed above? Y or N  If yes, please list:  To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.													
Do you now have or have you had any disease, condition, or problem not listed above? Y or N If yes, please list:  To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.				1				L .					
information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.	Do you now have or									110			
information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.	To the best of mv k	nowleda	e. the	questions on this form	n have	been	accı	ırately answered. Lund	dersta	าd tha	t providing incorrect		
Patient Signature	information can be											cal	
i ativit vigilatary	Patient Signature								Dat	e:			