



	ENT NUMBER			
welcome	Age Date			
Patient's Name	Date of Birth Male Female			
Last First	Initial			
If Child: Parent's Name	DENTAL INSURANCE			
How do you wish to be addressed	1ST COVERAGE  Date of Birth			
Residence - Street	Relationship to patient			
	Name of Insurance Co.			
City State Zip	Auditoss			
Business Address	Telephone			
Telephone: Res Bus				
Fax Cell Phone #	Social Security No.			
eMail	DENTAL INSURANCE			
Patient/Parent Employed By	= 2ND COVERAGE  Employee Name Date of Birth			
	Relationship to patient			
Present Position	Yrs.			
How Long Held	Name of Insurance Co. Address			
Spouse/Parent Name				
Spouse Employed By	Telephone Program or policy #			
Present Position	Social Security No.			
	Union Local or Group			
How Long Held	L consent to the diagnostic procedures and treatment by the dentist			
Who is Responsible for this account	necessary for proper dental care.			
Drivers License No.	I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities			
Method of Payment: Insurance □ Cash □ Credit Card □	and health care operations that are related to treatment or payment.			
Purpose of Call	I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or			
Other Family Members in this Practice	payment for that care			
	My consent to disclosure of records shall be effective until I revoke it in			
Whom may we thank for this referral	writing.			
Patient/parent Social Security No.	benefits other-wise payable to me. I understand that my dental care			
Spouse/Parent Social Security No.	actual bill for services, and that I am finan-cially responsible for payment in			
Someone to notify in case of emergency	tall of all adocument by organing time statement, i revente all provides			
	DATE			



P	ATII	ENT	NUN	иве	R

\	VEICOME Patient's Name	First	Initial Date of Birth
1.	Purpose of initial visit		COMMENTS
2.	Are you aware of a problem?		COMMENTS
		.	
	How long since your last dental visit?		
4.	What was done at that time?	I	
5.	Previous dentist's name		
6.	When was the last time your teeth were cleaned?		
CH	HECK THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, LEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.		
7.	Have you made regular visits? YES NO How often:		
8.	Were dental x-rays taken? YES NC	)	
9.	Have you lost any teeth or have any teeth been removed? YES NC		
10 11	Why? Have they been replaced?		
	a. Fixed bridge Age b. Removable bridge Age	.	
	b. Hemovable bridge Age	.	
	c. Denture Age d. Implant Age	·	
12	Are you unhappy with the replacement? YES NO	•	
40	If yes, explain	-	
14	. Would you like to know about permanent replacements? YES NO . Have you ever had any problems or complications with previous dental treatment? . YES NO . If yes, explain: YES NO YES NO	- 1	
15	. Do you clench or grind your teeth? YES NO		
16	. Does your jaw click or pop?		
	. Have you experienced any pain or soreness in the muscles or your face or around your ear?YES NO		
18	. Do you have frequent headaches, neckaches or shoulder aches? YES NO		
	Does food get caught in your teeth? YES NO		
20	. Are any of your teeth sensitive to: ☐ Hot? ☐ Cold? ☐ Sweets? Pressure?		
	Do your gums bleed or hurt?		
22 23	Do you experience dry mouth?	_	
	Do you use dental floss?		
25	. Are any of your teeth loose, tipped, shifted or chipped? YES NO		
	Are you unhappy with the appearance of your teeth? YES NO . How do you feel about your teeth in general?		
28	. Do you feel your breath is offensive at times? YES NO		
	. Have you ever had gum treatment or surgery? YES NO What? Where?	- 1	
	When?	.	
30	. Have you had any orthodontic work?	.	
	. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?		
32	strongly dislike? Do you have any questions or concerns?		
I C	CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE ATIENT'S / GUARDIAN'S SIGNATURE		DATE
DE	ENTIST'S SIGNATURE		DATE

ANEST.

MED. ALERT



P	ATIF	ENT	NUN	ИВЕ	R

CHECK THE APPROPARE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WITE "FONT KNOW ON THE LINE AFTER THE OUESTION."  1. Physician's Name Address Test:  Are you alker a physician's care?  3. When was your last complete physical exam?  4. Are you alker a physician's care?  5. When was your last complete physical exam?  4. Are you alker a physician's care?  6. Are you alker a physician's care there are the state suppliered the state suppl		Patient's Name Last	First		Date of Birth
Address  Tel:  2. Are you under a physician's care? Since when Why  3. When was your last complete physical exam?  If yes, please list medications in comments section or on the back of this form.)  If yes, please list medications in comments section or on the back of this form.)  If yes, please list medications in comments section or on the back of this form.)  If yes, please list medications in comments section or on the back of this form.)  If yes, please list medications in comments section or on the back of this form.)  An you allergic to any medications or substances? (please list)  YES NO  Any you allergic to any medications or substances? (please list)  Do you take was quietieps or hives?  Any you serial value lieties or hives?  Any you serial value lieties or hives?  Any you serial value or suspect you may be?  YES NO  Any you prepain or suspect you may be?  YES NO  Any you serial or suspect you may be?  YES NO  Any you serial or suspect you may be?  YES NO  Any you serial with mitar al way problems with periodicins?  YES NO  Any you serial with mitar al way problems?  YES NO  Any you serial with mitar al way problems?  YES NO  Any you serial with mitar al way problems?  YES NO  Any you were had thermatic lever?  YES NO  Any you were had a serious illness or major suspery?  YES NO  Any you were had a serious illness or major suspery?  YES NO  If you have injury or how to condition?  YES NO  If you have injury or how condition or you have you were had addition treatment (pictophophonates) for bone turnors, excessive calcium in your blood, or oreleoproosis?  YES NO  Do you have any artificial principle problems?  YES NO  Do you have any artificial principle problems?  YES NO  Do you have any artificial principle problems?  YES NO  Do you have any stream for Sama, such a artificial rehumatism?  YES NO  Do you have any stream for Sama, such a artificial rehumatism?  YES NO  Do you have any stream for some your and you have problems?  YES NO  Do you have any to dood goodestes, such a artificial rehumatism?			ER,		
Tel:  Are you under a physician's care?  Since when  Why  Why  Who was your last complete physical exam?  A any you lately only medications or substances?  Yes NO  If yes, please list medications in comments section or on the back of this form.)  5. Do you have any altergiace or hives?  A you take the only medications or substances? (Vitamins, herbal supplements, natural products).  7. Do you have any altergiace or hives?  A you was proprised by any medications or substances? (Please list).  8. Do you have any altergiace or hives?  A you was proprised to any medication so substances? (Please list).  9. Any you program or suspect you may be?  9. Any you program or suspect you may be?  9. Any you program or suspect you may be?  9. Any you program or suspect you may be?  9. Any you over been freated for or been tody you might have heart disease?  9. YES NO  10. You have any profit control medications?  9. YES NO  10. You have any profit control medications?  9. YES NO  10. You have any find heart wave implant, or  10. You have any find heart wave implant, or  10. YES NO  10. You have any find heart wave implant, or  11. Have you over that dheamatic lever?  12. Are you over that of such any find heart wave implant, or  12. Have you over that dheamatic lever?  13. Any you over had seeficious liness or major surgept?  14. Have you over that disablent treatment, chemo treatment for tumor,  15. Any you over that of sealants, Zometa, Aredia or any other or all intervenous treatment  15. See spalin  16. Boy have have plant of your body of pressure?  17. Have you over that of sealants, Zometa, Aredia or any other or all intervenous treatment  18. Have you over that of seases, such as antithe or incumation?  19. Have you over the discossively after bring out or injured?  19. Have you over the discossively after bring out or injured?  19. Do you have any stonach problems?  19. YES NO  19. Do you have any stonach problems?  19. YES NO  19. Do you have any stonach problems?  19. YES NO  19. Do you have any stonach problems?	1.	Physician's Name			
2. Air eyo under a physician's care?					
Since when					
3. When was your last compiles physical exam? 4. Are you bating any medications or substances? 6. Are you shall related substances? (Varians, health's applements, natural products). 7. By you have had hir related substances? (Varians, health's applements, natural products). 8. No 8. Do you have any problems with penicillin, antiblotics, anesthetics, 9. The product of the production of the product of the prod				NO	
4. Are you taking any medications or substances?		Since whenWhy			
If yes, please list medications in comments section or on the back of this form.)  5. Do you take with "related substances?" (please list).  6. Are you allergic to any medications or substances? (please list).  7. Do you have any allergies or hives?  8. Do you have any allergies or hives?  8. Do you have any problems with penicillin, antibiotics, anesthetics, or orther medications?  9. Are you sensitive to any metals or later?  9. Are you userand or suspect you may be?  9. Are you userand or suspect you may be?  10. De you use any bith control medications?  9. YES NO  9. Are you userand or suspect you may be?  10. De you use any bith control medications?  9. YES NO  10. De you use any bith control medications?  11. De you use any bith control medications?  12. Have you ever been treated for or been told you might have heart disease?  13. Do you have a pacemaker, an artificial heart valve implant, or you have a pacemaker, an artificial heart valve implant, or you were been treated for or been told you might have heart disease?  15. Are you aware of any heart murmurs?  16. De you have high or low blood pressure? (state high or low).  17. Have you ever had a serious illness or major surgery?  18. Have you ever had a radiation treatment, chemo treatment for tumor, growth or other condition?  19. Have you ever had a radiation treatment, chemo treatment for tumor, growth or other condition?  19. Have you ever had a radiation treatment, chemo treatment in your blood, or octeoprosis?  19. Have you ever had a radiation treatment, chemo treatment in your blood, or octeoprosis?  19. Do you have any plictod disorders, such as amemia, leukemia, etc?  19. YES NO  19. De you have any plictod glosders, such as amemia, leukemia, etc?  19. YES NO  19. De you have any tidendy problems?  19. YES NO  19. De you have any tidendy problems?  19. YES NO  19. De you have any tidendy problems?  19. YES NO  19. De you have any tidendy problems?  19. YES NO  19. De you have any tidendy problems?  19. YES NO  19. De you have any tidendy pro					
5. Do you have any proteins with periodic any americation or substances? (please list) 7. Do you have any allerigies or hives? 8. Do you have any proteins with periodilin, antibiotics, anesthetics, 9. Are you ansitive to any metals or latex? 9. Are you service to any metals or latex? 9. Are you service to any metals or latex? 9. Are you service to any metals or latex? 9. Are you service to any metals or latex? 9. Are you service to any metals or latex? 9. Are you service to any metals or latex? 9. Are you service to any metals or latex? 9. Are you service to any metals or latex? 9. Are you service to any metals or latex? 9. YES NO 9. Are you service the treaded for or been told you might have heart disease? 9. YES NO 9. Any or ware the treated for or been told you might have heart disease? 9. YES NO 9. Any or ware deet metal deal for or been told you might have heart disease? 9. YES NO 9. Any or ware of any heart furnimums? 9. Are you serve that dheumatic fever? 9. YES NO 9. Are you serve that dheumatic fever? 9. YES NO 9. Any or ware of any heart furnimums? 9. Are you ware that disease or major surgery? 9. YES NO 9. Are you have high or low blood pressure? (state high or low) 9. YES NO 9. Are you have high or low blood pressure? (state high or low) 9. YES NO 9. Are you have any ware that a serious illiness or major surgery? 9. If you have any ware that a ferious illiness or major surgery? 9. If you have any serve that disease or major surgery? 9. NO 9. Do you have any afficial joints/prosthesis? 9. YES NO 9. Do you have any afficial joints/prosthesis? 9. YES NO 9. Do you have any afficial joints/prosthesis? 9. YES NO 9. NO 9. Do you have any afficial joints/prosthesis? 9. YES NO 9. NO 9. Do you have any afficial joints/prosthesis? 9. YES NO 9. NO 9. Do you have any afficial joints/prosthesis? 9. YES NO 9. NO 9. Do you have any afficial joints/prosthesis? 9. YES NO 9. NO 9. Do you have any afficial joints/prosthesis? 9. YES NO 9. NO 9. Do you have any afficial joints/prosthesis? 9. YES NO 9. NO 9. Do you have a	4.		YES	NO	
6. Are you allergic to any medications or substances? (please list) YES NO 7 NO you have any lergices or hive with early 100 No	_				
7. Do you have any pollengies or hives? YES NO So Do you have any problems with periodlin, antibiotics, anesthetics, or other medications? YES NO YES					
8. Do you have any problems with penicillin, antibiotics, anesthetics, or other medications? 9. Are you sensitive to any metals or latex? 9. Are you sensitive to any metals or latex? 9. VES NO 11. Do you use any birth control medications? 12. Have you ever been treated for or been told you might have heart disease? 13. Do you have a pacemaker, an artificial heart valve implant, or been diagnosed with mitral valve prolapse? 9. VES NO 14. Have you ever had theumatic levelvor? 9. VES NO 15. Are you aware of any heart murmurs? 16. Do you have high or fow bodo pressure? (state high or low) 17. Have you ever had a setious liness or major surgery? 18. No 19. Have you ever had a setious liness or major surgery? 19. Have you ever had a setious liness or major surgery? 19. Have you ever had radiation treatment, chemo treatment for humor, growth or other condition? 19. Have you ever had radiation treatment, chemo treatment for humor, growth or other condition? 19. Have you ever had radiation treatment, chemo treatment for humor, growth or other condition? 19. Have you ever had radiation treatment, chemo treatment for humor, growth or other condition? 19. Have you ever laken Fosamax, Zometa, Aredia or any other oral intravenous treatment (hisphosphonates) for bone humoris, excessive calcium in your blood, or osteoporosis? 19. Do you have any artificial joints/prosthesis? 10. Do you have any strificial joints/prosthesis? 10. Do you have any strificial joints/prosthesis? 10. Do you have any strificial joints/prosthesis? 10. Do you have any filter politics or demandating or demandatin					
or other medications? YES NO S Are you sensitive to any metals or latex? YES NO S Are you sensitive to any metals or latex? YES NO S Are you pregnant or suspect you may be? YES NO S Are you pregnant or suspect you may be? YES NO S NO			YES	NO	
9. Are you sensitive to any metals or latex? YES NO (abey ou pregnant or suspect you may be? YES NO (b) and you want of the property of the pr	ŏ.				
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11. Do you uses any birth control medications?		·			
12. Have you ever been treated for or been told you might have heart disease? YES NO been diagnosed with mitral valve prolegase? YES NO heart along the provided of the prov			_		
13. Do you have a pacemaker, an artificial heart valve implant, or been diagnosed with mitral valve prolapse?   YES NO					
been diagnosed with mitrial valve prolapse?  15. Are you aware of any heart murmurs?  15. Are you aware of any heart murmurs?  16. Do you have high or low blood pressure? (state high or low)  17. Have you ever had a serious liness or major surgery?  18. Have you ever had a serious liness or major surgery?  19. Have you ever had a fosamax, Zometa, Aredia or any other oral intravenous treatment (hisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis?  19. Have you ever taken Fosamax, Zometa, Aredia or any other oral intravenous treatment (hisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis?  19. Have you ever late of Fosamax, Zometa, Aredia or any other oral intravenous treatment (hisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis?  19. Have you ever had eafous any artificial jointifyorosthesis?  19. Do you have any artificial jointifyorosthesis?  19. Do you have any stomach problems, as anemia, leukemia, etc?  19. Do you have any stomach problems?  19. Do you have any jiver problems?  19. Do you have any jiver problems?  19. No  19. Do you have any jiver problems?  19. No  19. Do you have any liver problems?  19. No  19. Do you have pulpers or seizure disorders?  19. No  19. Do you have you had venereal or any sexually transmitted disease?  19. No  19. Do you ave you have you had venereal or any sexually transmitted disease?  19. No  19. Do you requising or discrete disorders?  19. No  19. Do you requising or or seizure disorders?  19. No  19. Do you requising or or seizure disorders?  19. No  19. Do you requising or or seizure disorders?  19. No  19. Do you requising or or seizure disorders?  19. No  19. Do you requising or or seizure disorders?  19. No  19. Do you requising or or seizure disorders?  19. No  19. Do you requising or or seizure disorders?  19. No  19. Do you requising or seizure disorders?  1			YES	NO	
14. Have you ever had rheumatic fever?	13.		VEO	NO	
15. Are you aware of any heart murmurs?					
16. Do you have high or low blood pressure? (state high or low)   YES NO					
17   Have you ever had a serious lilness or major surgery?   YES   NO     18   Have you ever had a serious lilness or major surgery?   YES   NO     19   Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition?   YES   NO     19   Have you ever had radiation treatment, chemo treatment (pisphosphonates) for bone tumors, excessive calcium in your blood, or osteporosis?   YES   NO     19   Have you ever had radiation treatment, chemo treatment (pisphosphonates) for bone tumors, excessive calcium in your blood, or osteporosis?   YES   NO     10   YES   NO   YES   NO     10   YES   NO   YES   NO     12   Do you have any artificial joints/prosthesis?   YES   NO     12   Do you have any stomach problems?   YES   NO     13   Have you ever bled excessively after being cut or injured?   YES   NO     14   YES   NO   YES   NO     15   Do you have any stomach problems?   YES   NO     16   Do you have any stomach problems?   YES   NO     17   Are you diabetic?   YES   NO     17   Are you diabetic?   YES   NO     18   YES   NO   YES   NO     19   Do you have any stomach problems?   YES   NO     19   Do you have any stomach problems?   YES   NO     19   Do you have any stomach problems?   YES   NO     10   Do you have any stomach problems?   YES   NO     10   Do you have any stomach problems?   YES   NO     10   Do you have any stomach problems?   YES   NO     11   Do you have any stomach problems?   YES   NO     12   Do you have any stomach problems?   YES   NO     13   Do you and you have any stomach problems?   YES   NO     14   Have you have any stomach problems   YES   NO     15   Do you or have you had or do you test positive for hepatitis?   YES   NO     16   Do you or have you had or do you test positive for hepatitis?   YES   NO     17   Do you regularly consume more than one or two alcoholic beverages a day?   YES   NO     18   Have you had psychiatric treatment?   YES   NO     19   Have you had have any prescription drugs felturamine, fenifuramine combined with phentermine (fen-p			_		
If so, explain  18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition?  19. Have you ever taken Fosamax, Zometa, Aredia or any other oral intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis?  19. Have you ever taken Fosamax, Zometa, Aredia or any other oral intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis?  19. Do you have any afficial pinits/prosthesis?  10. Do you have any stificial pinits/prosthesis?  11. Do you have any blood disorders, such as anemia, leukemia, etc?  12. Do you have any blood disorders, such as anemia, leukemia, etc?  13. Have you ever bled excessively after being cut or injured?  14. Do you have any kidney problems?  15. Do you have any kidney problems?  16. Do you have any liver problems?  17. Are you diabetic?  18. No  19. Do you have any liver problems?  19. Do you have any liver problems?  19. No  10. Do you on tave any liver problems?  19. No  10. Do you on tave you had veneral or any sexually transmitted disease?  19. No  10. Do you have you had veneral or any sexually transmitted disease?  19. No  19. Have you lave you had veneral or any sexually transmitted disease?  19. Have you had or do you test positive?  19. Have you had or do you test positive for hepatitis?  19. No  19. Do you or have you had or not you have forms of tobacco?  19. YES NO  20. Do you have any love sexually transmitted disease?  21. Have you lad or do you test positive for hepatitis?  22. Have you lad or do you test positive for hepatitis?  23. Have you lad or do you test positive for hepatitis?  24. Have you had or do you test positive for hepatitis?  25. No  26. Do you have any formation or two alcoholic beverages a day?  27. YES NO  28. Do you have any formation or two alcoholic beverages a day?  28. No  29. Have you had posphaliatic teatment?  29. No  20. Have you have any goisease condition, or problem not listed? If so, explain  29. No  20. Have you hav					
B. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition?   YES NO     9. Have you ever taken Fosamax, Zometa, Aredia or any other oral intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoprosis?   YES NO     10. Do you have any artificial joints/prosthesis?   YES NO     21. Do you have any stodd disorders, such as anemia, leukemia, etc?   YES NO     22. Do you have any blood disorders, such as anemia, leukemia, etc?   YES NO     23. Have you ever lade accessively after being cut or injured?   YES NO     24. Do you have any stomach problems?   YES NO     25. Do you have any stomach problems?   YES NO     26. Do you have any liver problems?   YES NO     27. Are you diabetic?   YES NO     28. Do you have any liver problems?   YES NO     29. Do you have any liver problems?   YES NO     29. Do you have ashima?   YES NO     29. Do you have ashima?   YES NO     30. Do you have ashima?   YES NO     40. Do you have ashima?   YES NO     50. Do you have politapsy or seizure disorders?   YES NO     50. Do you have politapsy or seizure disorders?   YES NO     50. Do you have politapsy or seizure disorders?   YES NO     50. Do you have politapsy or seizure disorders?   YES NO     50. Do you have politapsy or seizure disorders?   YES NO     50. Do you have politapsy or seizure disorders?   YES NO     50. Do you have politapsy or seizure disorders?   YES NO     50. Do you have politapsy or seizure disorders?   YES NO     50. Do you have politapsy or seizure disorders?   YES NO     50. Do you have politapsy or seizure disorders?   YES NO     50. Do you have politapsy or seizure disorders?   YES NO     50. Do you have politapsy or seizure disorders?   YES NO     50. Do you have politapsy or seizure disorders?   YES NO     50. Do you smoke, chew, uses nuff or any other forms of tobacco?   YES NO     50. Do you smoke, chew, uses nuff or	17.		ILO	NO	
growth or other condition?    Have you ever taken Fosamax, Zometa, Aredia or any other oral intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis?   YES NO	12				
Have you lever taken Fosamax, Zometa, Aredia or any other oral intravenous treatment (pisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis? YES NO	10.		YES	NO	
(bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis? YES NO 20. Do you have inflammatory diseases, such as arthritis or rheumatism? YES NO	10			110	
20. Do you have inifiammatory diseases, such as arthritis or rheumatism? YES NO	10.		YES	NO	
Do you have any artificial joints/prosthesis?   YES NO	20				
22. Do you have any blood disorders, such as anemia, leukemia, etc? 23. Have you ever bled excessively after being cut or injured? 24. Do you have any stomach problems? 25. Do you have any kidney problems? 26. Do you have any kidney problems? 27. Are you diabelic? 28. Do you have any liver problems? 28. Do you have any liver problems? 29. Do you have ashima? 29. Do you have ealthing or dizzy spells? 29. Do you have ealthing or dizzy spells? 29. Do you have ealthing or dizzy spells? 29. Do you have ealthing? 30. Do you have ealthing? 31. Do you or have you had venereal or any sexually transmitted disease? 31. Do you or have you had venereal or any sexually transmitted disease? 31. Do you or have you had or do you tested HIV positive? 32. Have you tested HIV positive? 33. Do you or have you had or do you test positive for hepatitis? 34. Have you had or do you test positive for hepatitis? 35. Do you or have you had T.B.? 36. Do you smoke, chew, use snuff or any other forms of tobacco? 37. Do you guglarly consume more than one or two alcoholic beverages a day? 38. Do you had psychiatric treatment? 49. Have you had psychiatric treatment? 40. Have you had psychiatric treatment? 41. Have you had psychiatric treatment? 42. Is there anything else we should know about your health that we have not covered in this form? 45. Would you like to speak to the Doctor privately about any problem? 40. ICERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE 40. PATIENT'S / GUARDIAN'S SIGNATURE 41. DATE			_		
All Have you ever bled excessively after being cut or injured?  Do you have any stomach problems?  Do you have any stomach problems?  Do you have any liver problems?  YES NO  YES NO  YES NO  YES NO  YES NO  Do you have any liver problems?  YES NO  YES NO  Do you have fainting or dizzy spells?  Do you have sathma?  YES NO  Do you have eathma?  YES NO  YES NO  Do you have epilepsy or seizure disorders?  YES NO  JO you on have epilepsy or seizure disorders?  YES NO  JO you on have epilepsy or seizure disorders?  YES NO  JO you on have epilepsy or seizure disorders?  YES NO  JO you on have all V positive?  YES NO  JO you have all NO  JO you have all you test positive for hepatitis?  YES NO  JO you on have you had T.B.?  YES NO  JO you on have you had T.B.?  JO you on have you had you had no do you test positive for hepatitis?  YES NO  JO you on have you had you had no no or two alcoholic beverages a day?  YES NO  JO you have ally secontrolled substances?  YES NO  JO you have you had psychiatric treatment?  Have you had psychiatric treatment?  Have you had psychiatric treatment?  YES NO  JO you have you had psychiatric treatment?  YES NO  JO you have any disease condition, or problem not listed? If so, explain  YES NO  YES NO  YES NO  YES NO  JO you have any disease condition, or problem not listed? If so, explain  YES NO  YES NO  YES NO  YES NO  YES NO  YES NO  JO you have any disease to the Doctor privately about any problem?  I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE  PATIENT'S / GUARDIAN'S SIGNATURE			YES	NO	
24. Do you have any stomach problems? 25. Do you have any kidney problems? 26. Do you have any kidney problems? 27. Are you diabetic? 28. Do you have fainting or dizzy spells? 29. Do you have asinting or dizzy spells? 29. Do you have eainting or dizzy spells? 29. Do you have eainting or dizzy spells? 29. Do you have epilepsy or seizure disorders? 20. Do you have epilepsy or seizure disorders? 20. Do you have poul had venereal or any sexually transmitted disease? 21. NO 22. Have you tested HIV positive? 23. Do you have AIDS? 24. Have you tested HIV positive? 25. NO 26. Do you or have you had or do you test positive for hepatitis? 26. Do you or have you had or do you test positive for hepatitis? 27. Do you group on the you had T.B.? 28. NO 29. Do you smoke, chew, use snuff or any other forms of tobacco? 29. YES NO 29. Have you had psychiatric treatment? 29. NO 20. Use on the problem of the poor of the weight loss products? 29. NO 20. Use on the problem of the problem of the problem? 20. Is there anything else we should know about your health that we have not covered in this form? 30. Would you like to speak to the Doctor privately about any problem? 31. CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE PATIENT'S / GUARDIAN'S SIGNATURE			YES	NO	
Do you have any kidney problems? YES NO YES					
26. Do you have any liver problems? YES NO 27. Are you diabetic? YES NO 28. Do you have fainting or dizzy spells? YES NO 29. Do you have fainting or dizzy spells? YES NO 29. Do you have asthma? YES NO 20. Do you have expilepsy or seizure disorders? YES NO 20. Do you have expilepsy or seizure disorders? YES NO 20. Do you have expilepsy or seizure disorders? YES NO 20. Do you have expilepsy or seizure disorders? YES NO 20. Do you have expilepsy or seizure disorders? YES NO 20. Have you had venereal or any sexually transmitted disease? YES NO 20. Have you tested HIV positive? YES NO 21. Have you tested HIV positive? YES NO 22. Have you test positive for hepatitis? YES NO 23. Do you not alou you test positive for hepatitis? YES NO 24. Have you had or do you test positive for hepatitis? YES NO 25. Do you or have you had T.B.? YES NO 26. Do you smoke, chew, use snuff or any other forms of tobacco? YES NO 27. Do you regularly consume more than one or two alcoholic beverages a day? YES NO 28. Do you habitually use controlled substances? YES NO 29. Have you had psychiatric treatment? YES NO 30. Have you had psychiatric treatment? YES NO 30. Have you taken any prescription drugs fneffuramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? YES NO 30. Have you taken any prescription drugs fneffuramine full fiso, explain YES NO 31. Is there anything else we should know about your health that we have not covered in this form? 32. Is there anything else we should know about your health that we have not covered in this form? 33. Would you like to speak to the Doctor privately about any problem? YES NO 34. Is there anything else we should know about your health that we have not covered in this form? 34. Would you like to speak to the Doctor privately about any problem? 34. Have you had the problem? YES NO 35. Do you habitually use controlled substances? YES NO 36. Do you habitually use controlled substances? YES NO 37. Do you habitually use controlled substances? YES N					
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32. Have you tested HIV positive?			YES	NO	
33. Do you have AIDS?			YES	NO	
34. Have you had or do you test positive for hepatitis?			YES	NO	
35. Do you or have you had T.B.?	34.	Have you had or do you test positive for hepatitis?		NO	
36. Do you smoke, chew, use snuff or any other forms of tobacco?	35.	Do you or have you had T.B.?		NO	
Do you regularly consume more than one or two alcoholic beverages a day?	36.	Do you smoke, chew, use snuff or any other forms of tobacco?	YES	NO	
38. Do you habitually use controlled substances?			YES	NO	
Have you had psychiatric treatment?			YES	NO	
Have you taken any prescription drugs fnefluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products?			YES	NO	
(fen-phen), dexfenfluramine (redux), or other weight loss products?					
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43. Would you like to speak to the Doctor privately about any problem?  I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE  PATIENT'S / GUARDIAN'S SIGNATURE  DATE  DATE	10	la thous anothing also are about linear should be a superior to the thought of the state of the			
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MEDICAL HISTORY © 2007 Wisconsin Dental Association (800) 243-4675

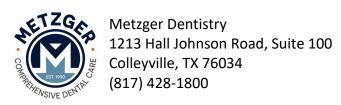
MED. ALERT



## **ACKNOWLEDGEMENT OF RESPONSIBILITY**

I have read, verified and completed the Patient Registration forms, dated \_\_\_\_\_\_\_,

and I can attest to their accuracy to the best of my knowledge.
I understand it is my responsibility to inform your office of any information changes, insurance changes, or phone/address changes at the time I sign in for each appointment. Any information withheld could affect my insurance coverage and make me responsible for payment at the time of service.
I understand that I am legally responsible for <b>all charges</b> incurred for my care.
Payment is expected when services are rendered, unless alternative arrangements have been made in advance.
As a courtesy to me, the office of <b>Metzger Dentistry</b> , will attempt to gather as much information as possible regarding my insurance. It is my full responsibility to be aware of all coverage and benefits on my policy.
I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to <b>Metzger Dentistry</b> . I understand that I am financially responsible for any balance not covered by my insurance company.
I understand that any remaining balance which is over 30 days past due will be paid upon receipt of statement. I understand that any unpaid account is considered delinquent after 30 days and is subject to collection action, through a service reporting to credit bureaus.
I understand that there will be a charge of \$20.00 for any returned checks.
I understand that if I am unable to keep my appointment, I must notify the office at least 24 hours before my scheduled appointment time.
Patient Name
Signature
Patient or legally responsible party
Date



## **INSURANCE AUTHORIZATION**

We realize that dental insurance is complex, and it can be difficult to understand the treatments covered by some dental insurance companies. As a courtesy to you, our office is happy to help you process your insurance. We will do everything possible to help you understand and make the most of your dental insurance benefits.

Insurance coverage is usually limited to a portion of the fee agreed to by you and our office. The benefits that you will receive are based on the terms of the contract that were negotiated between your employer and the dental insurance company. Unfortunately, some of the services that you may need will not be covered by your dental insurer. Our goal is to help you achieve and maintain optimal dental care, which is not necessarily the goal of the dental insurance companies.

Our office will complete and submit dental insurance forms to the insurance company to achieve the maximum reimbursement to which you are entitled. We will work diligently to complete the process as quickly as possible.

Please let us know if you have any questions about your dental insurance coverage. It will be our