DENTAL REGISTRATION AND HISTORY

PATIENT INFORMAT	ION	DENTA	AL INSURANCE	Physician's Name
ia, Oldrenos, Scenus, 11 Yes 11 No.	AND REPORTED AND PARTY OF THE P	id ripinanoù S	noderille a ofstverlozofigeld s	beau teve poy evert
Date	CONTRACTOR	on the contribution with the con-	onsible for this account?	16NET JEANS THOR GARST -
SS/HIC/Patient ID #	Re	elationship to Patie	nt contraction, tendence in	names of phentero
Patient Name	Ins	nsurance Co	ed ucy it arratem at you he to	Place a mancon sp
MAC adv Cl	Gr	iroup #		A STATE OF THE PARTY OF THE PAR
First Name	Middle Initial Is	patient covered by	additional insurance? Yes	□No
Address	OM CT ON TO	ubscriber's Name_		Antifecti Hearn Value
E-mail_	Bi	irthdate	SS#	elinos IncinutA
City	Re	elationship to Patie	nt_MATT BOY ET	Back Problems
State Zip	MATCH WATCH	nsurance Co		Bleeding Abnormalia
Sex M F Age	STATE OF THE REAL PROPERTY OF THE PERSON.		SMIT WAY	
Birthdate		SSIGNMENT AND RE		Cancer
☐ Married ☐ Widowed ☐ Single			or my dependent(s), have insu	rance coverage with
☐ Separated ☐ Divorced ☐ Partnered	foryears	Name of Ins	surance Company(ies)	and assign directly to
Patient Employer/School		r. arti evray aprilist	DATE BYOM ending	all insurance benefits, if
Occupation	an	ny, otherwise payable	to me for services rendered. I or all charges whether or not paid b	understand that I am
Employer/School Address	the		on all insurance submissions.	e atectal (
			ist may use my health care information above-named Insurance Companies	
Employer/School Phone ()	for be		aining payment for services and payable for related services. This	
Spouse's Name		y current treatment pl	an is completed or one year from t	he date signed below.
Birthdate		Signature of Pat	ient, Parent, Guardian or Personal	Representative
SS# PRINTERIA	COLLEGE SECTION OF THE PROPERTY OF THE PROPERT		MEDICATIONS	
Spouse's Employer		Please print name of	Patient, Parent, Guardian or Person	onal Representative
Whom may we thank for referring you?	THE PERSON NAMED AS A PERSON NAMED A PERSON NAMED AS A PERSON NAMED A PERSO	Date	Relationsh	nip to Patient
		Service Assessed		
PHONE NUMBERS	Course-Sin Town			
Disease and El	Work ()	-	Call (Pharmady Halife
Phone ()				Phone ()
Spouse's Work ()_ IN CASE OF EMERGENCY, CONTACT (Specific				
Name			TES (To be filled in a	A LIPDA
Home Phone ()	VVOIK	Phone ()_		
DENTAL HISTORY				ESCHELLE SET HER
		STREET OF STREET	Sa total black was	Are you telong any I
Reason for today's visit	Burning sensation on tongue	☐ Yes ☐ No	Mouth breathing	☐ Yes ☐ No
	Chew on one side of mouth Cigarette, pipe, or cigar smoking	☐ Yes ☐ No	Mouth pain, brushing Orthodontic treatment	☐ Yes ☐ No ☐ Yes ☐ No
Former Dentist	Clicking or popping jaw	yes □ No	Pain around ear	☐ Yes ☐ No
City/State	Dry mouth	☐Yes ☐ No	Periodontal treatment	☐ Yes ☐ No
Date of last dental visit	Fingernail biting	☐ Yes ☐ No	Sensitivity to cold	☐ Yes ☐ No
Tail of last dollar flori	Food collection between the teeth		Sensitivity to heat	Yes No
Date of last dental V roug	Foreign objects	☐ Yes ☐ No	Sensitivity to sweets	☐ Yes ☐ No
Date of last dental X-rays	AND THE RESIDENCE OF THE PARTY	TVes TNo	Sensitivity when hiting	□Yes □No
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Grinding teeth Gums swollen or tender	☐ Yes ☐ No☐ Yes ☐ No☐	Sensitivity when biting Sores or growths in your mou	☐ Yes ☐ No uth ☐ Yes ☐ No
Place a mark on "yes" or "no" to indicate if you	Grinding teeth Gums swollen or tender		Sores or growths in your mou	uth Yes No
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Grinding teeth Gums swollen or tender Jaw pain or tiredness	☐ Yes ☐ No	Sores or growths in your mou	

Physician's Name						Date of last visit		
The state of the s			n? Common brand names	are Fosamax A	Actonel Ate		□No	
	ne group	of drugs co	ollectively referred to as "fe	n-phen?" These		ombinations of Ionimin, Adipex, Fa	atres.	nd
Place a mark on "yes" or "no"				The State of the S				
AIDS/HIV		□No	Epilepsy		□No	Respiratory Disease	☐Yes	DN
Anemia	A CONTRACTOR OF	□No	Fainting or dizziness	□Yes		Rheumatic Fever	☐Yes	
Arthritis, Rheumatism		□ No	Glaucoma	□Yes	A Link Street Land	Scarlet Fever	☐Yes	
Artificial Heart Valves	☐Yes	No. of the last of	Headaches	□Yes	□No	Shortness of Breath	☐Yes	
Artificial Joints		□No	Heart Murmur	□Yes	STREET, SQUARE, STREET,	Sinus Trouble	☐ Yes	
Asthma			Heart Problems	□Yes		Skin Rash	☐Yes	Total Control
Back Problems	1000	□ No	Hepatitis Type	Yes		Special Diet	Yes	
Bleeding abnormally, with		□ No	Herpes	□Yes	STATE OF THE PARTY	Stroke	Yes	
extractions or surgery			High Blood Pressure	□Yes	and the later of t	Swollen Feet or Ankles	Yes	100
Blood Disease	☐ Yes	□ No	Jaundice	□Yes	THE REAL PROPERTY.	Swollen Neck Glands	☐Yes	C. T. Sel
Cancer	Yes	□ No	Jaw Pain	□Yes		Thyroid Problems	Yes	
Chemical Dependency	Yes	□ No	Kidney Disease	□Yes		Tonsillitis	Yes	
Chemotherapy	Yes	□ No	Liver Disease	☐Yes	WHEN STREET	Tuberculosis	Yes	
Circulatory Problems	Yes	□ No	Low Blood Pressure		□ No	Tumor or growth on head or	Yes	Address of the
Congenital Heart Lesions	Yes	□ No	Mitral Valve Prolapse		□ No	neck		Broke
Cortisone Treatments	Yes	□ No	Nervous Problems	The State of the S	□ No	Ulcer	Yes	
Cough, persistent or bloody	☐ Yes	□ No	Pacemaker		□No	Venereal Disease	Yes	01
Diabetes	☐ Yes	□ No	Psychiatric Care	A CONTRACTOR OF THE PARTY OF TH	□ No	Weight Loss, unexplained	Yes	01
Emphysema	Yes		Radiation Treatment		□ No			
Do you wear contact lenses?	□Yes	□No	and to recognize all of a					
Vomen:	ON CHEST	TO SHIPS						
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MEI	DICA	TION	S			ALLERGIES		_ 6
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List any medications you are diagnosis:	currently	taking and	the correlating	☐ Barbiturate	es (Sleepir	☐ Local Anesthetic ng pills) ☐ Penicillin ☐ Sulfa		artio article
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Pharmacy Name	currently	taking and	the correlating	☐ Barbiturate ☐ Codeine ☐ lodine ☐ Latex	es (Sleepir	☐ Local Anesthetic ng pills) ☐ Penicillin ☐ Sulfa		SENIOR SE
Pharmacy Name Phone () UPDATES	(To be	filled in	the correlating	☐ Barbiturate ☐ Codeine ☐ lodine ☐ Latex	MONE SOURCE	Local Anesthetic		SAO SAO
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charmacy Name Phone () UPDATES Has there been any For what conditions? Are you taking any new medic Patient's Signature Doctor's Signature	(To be change cations?	filled in	at future appointment alth since your last dental a	Barbiturate Codeine Iodine Latex	Yes Daniel	Local Anesthetic ng pills) Penicillin Sulfa Other No Date Date	A H H H H H H H H H H H H H H H H H H H	SAO
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List any medications you are diagnosis: Pharmacy Name Phone () UPDATES	(To be cations?	filled in in your health since	at future appointment alth since your last dental appointment alth since your last dental appointment alth so, what?	Barbiturate Codeine Iodine Latex Ints Pappointment? Int? Yes Int? Yes Int? Yes Int?	Yes	Local Anesthetic ng pills)	A H H H H H H H H H H H H H H H H H H H	SAC