## Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental
care. To help us meet all your dental healthcare needs, please
fill out this form completely in ink. If you have any questions
or need assistance, please ask us - we will be happy to help.

		Patient #
Dationt Information		SS#/SIN
Patient Information	(CONFIDENTIAL)	Date
Name	Birthdate	Home Phone
Address	City	Prov. P.C.
Email	Cell Phone	
Check Appropriate Box: Minor Single	☐ Married ☐ Divorced ☐ Widowed ☐ Se	paratedFullPart
If Student, Name of School/College	City	State/ Full Part Time Time
Patient or Parent/Guardian's Employer		Work Phone
Business Address	City	State/ Zip/ ProvP.C.
Spouse or Parent/Guardian's Name	Employer	
Whom may we thank for referring you?		
Person to contact in case of emergency		Phone
Responsible Party		
		Relationship
	Birthdate Financial Institution	
Employer	Work Phone	SS#/SIN
Is this person currently a patient in our office?	□ Yes □ No	
For your convenience, we offer the following me	thods of payment. Please check the option you prefer. P	ayment in full at each appointment.
☐ Cash ☐ Personal Check Ci	redit Card 🗆 VISA 🗆 MasterCard 📁 I wish	to discuss the office's payment pôlicy.
<b>Insurance Informati</b>	ion	
		Relationship to Patient
Name of Insured	/SIN	
	Union or Local#	State/ Zin/
	City	
	Group#	State/ Zin/
	City	
How much is your deductible?	How much have you used?	Max. annual benefit
DO YOU HAVE ANY ADDITIONAL INSUR	RANCE? Yes No IF YES, COMP	PLETE THE FOLLOWING:
Name of Insured		Relationship to Patient
BirthdateSS#/S	SIN	Date Employed
Name of Employer	Union or Local#	Work Phone
	City	State/ Zip/ Prov. P.C.
Insurance Company		Policy/ID# Zip/
	City	State/ Zip/ Prov. P.C.
	How much have you used? M	lax, annual benefit
The man is join manufact.	Own Places	

nysicianOffice P	hone	Nr.	Date of Last Exam	Var	
4	Yes	No	10. Are you wearing contact lenses?	Ves	N
Are you under medical treatment now? Have you ever been hospitalized for any			11. Are you allergic to or have you had any reactions to the following?		
surgical operation or serious illness within the last 5 years?			Local Anesthetics (e.g. Novocain)		I
If yes, please explain			Penicillin or any other Antibiotics		
g yes, pictise explain			Sulfa Drugs		
Are you taking any medication(s)			Barbiturates		Ţ
including non-prescription medicine?			Sedatives		
If yes, what medication(s) are you taking?			Iodine		
7,50,770			Aspirin		1
Have you ever taken Fen-Phen/Redux?			Any Metals (e.g. nickel, mercury, etc.)	H	-
Have you ever taken Fosamax, Boniva, Actonel or any cancer			Latex Rubber		1
medications containing bisphosphonates?			Other (please list)		
Have you taken Viagra, Revati, Cialis or Levitra		7	12. Do you have a persistent cough or throat clearing not		
in the last 24 hours?			associated with a known illness (lasting more than 3 weeks)?	-	0.4
Do you use tobacco?			13. Women Only:		1
Do you use controlled substances?			a) Are you pregnant or think you may be pregnant?	H	
Do you have or have you had any of the following?			b) Are you nursing?	H	
Yes No			c) Are you taking oral contraceptives? Yes No		
			마이트(July 2004) (1997년 1일	Yes	
High Blood Pressure Heart Dis				H	
Heart Attack Cardiac I				H	
Rheumatic Fever				H	
			Hay Fever / Allergies	H	
Fainting / Seizures			Radiation Therapy	H	
Asthma			Glaucoma	H	
				H	
Epilepsy / Convulsions		Liver Disease	Ħ	1	
Diabetes Joint Rep			ant	Ħ	
Kidney Diseases Hepatitis			Respiratory Problems	Ħ	Pi
AIDS or HIV Infection				Ħ	L i
Thyroid Problem Stomach				n	
Patient Dental History					
rme of Previous Dentist and Location	Man	N1.	Date of Last Exam	37	
Do your gums bleed while brushing or flossing?	Yes	No		Yes	1
		8. Do you have frequent headaches?		Ħ	
Are your teeth sensitive to hot or cold liquids/foods? Are your teeth sensitive to sweet or sour liquids/foods?		H	9. Do you clench or grind your teeth?	Ħ	T
	The same of the sa	H	10. Do you bite your lips or cheeks frequently?		
Do you feel pain to any of your teeth?		-	11. Have you ever had any difficult extractions		T
Do you have any sores or lumps in or near your mouth?		H	in the past?	ш	
Have you had any head, nech or jaw injuries?			12. Have you ever had any prolonged bleeding		T
Have you ever experienced any of the following			following extractions?	H	1
problems in your jaw?			13. Have you had any orthodontic treatment?	H	-
Clicking		H	14. Do you wear dentures or partials?	-	1
Pain (joint, ear, side of face)		H	If yes, date of placement		
Difficulty in opening or closing			15. Have you ever received oral hygiene instructions		-
Difficulty in chewing			regarding the care of your teeth and gums?		53
Authorization and Releas	0		16. Do you like your smile?	ш	E
ertify that I have read and understand the above informati	ion to the igerous t endered i rance coi ince carr	best of one his best of the be	my knowledge. The above questions have been accurately an alih. I authorize the dentist to release any information inclusion my child during the period of such Denial care to third part to pay directly to the dentist or dental group insurance benefit pay less than the actual bill for services. I agree to be responsi	iswei ling y pa is sible	rec th tyo
					Seattle State of the State of t
	100	AL B	Date		
ignature of patient (or parent/guardian if minor)					_
ignature of patient (or parent/guardian if minor)  Doctor's Comments					