

Today's date:			
Touay S date:	 	 	

Name:								
Last		First	Prefer to be called					
Address:								
Street		City Pro			v Postal Code			
Talanhana								
Telephone:		Work			Cell		_	
Email:								
Date of Birth:Month/day/year	Age:	Sex:	ļ	Marital	Status:	_		
Month / day / year								
Employed by:		Occup	ation:					
How did you hear about our office	? Facebo	ook Google Yel	low Pages _.	Frier	nd/Family Blog E	xisting Pati	ents	
Medical Information								
Medical doctor:			Talanho	ano:				
Medical doctor: Date of last physical exam:								
Are you presently under the car								
Are you presently taking any mo								
	,		,	'	,			
Do you have any allergies or ha	ve you had	any reaction to (medi	cations, anest	thetics, m	etals, latex, antibiotics, pain	killers, dairy,		
etc.):								
Do you have to take antihiotics	prior to de	ntal work? If yes, wh	y?				_	
Have you had heart surgery? If								
Have you had heart surgery? If the Do you have any artificial prostl	hesis (Joints	s, heart valve, etc)? I	f yes pleas	se spec			_	
Have you had heart surgery? If the Do you have any artificial prostl	hesis (Joints	s, heart valve, etc)? I	f yes pleas	se spec			_	
Have you had heart surgery? If one of the prostles of the pros	hesis (Joints g? Yes _	s, heart valve, etc)? I No Do you beco	f yes pleas	se spec			_	
Have you had heart surgery? If one you have any artificial prostle Do you have abnormal bleeding Do you have or have had any o	hesis (Jointsg? Yes _ f the follow	s, heart valve, etc)? I No Do you beco ving:	f yes pleas ome breatl	se spec hless ea	asily? Yes No)		
Have you had heart surgery? If the post of	hesis (Joints g? Yes _ of the follow s No	s, heart valve, etc)? I No Do you beco ving: Glaucoma	f yes pleas ome breatl Yes	se spec hless ea No	asily? Yes No Heart murmur	Yes	N	
Have you had heart surgery? If the proof of	hesis (Joints 3? Yes _ of the follow s No s	s, heart valve, etc)? I No Do you beco ving: Glaucoma Diabetes	f yes pleas ome breatl Yes Yes	se spec hless ea No No	esily? Yes No Heart murmur Emphysema	Yes Yes	N	
Have you had heart surgery? If the Do you have any artificial prostly Do you have abnormal bleeding Do you have or have had any output blood pressure Yes Digestive disorders Yes Sinus problems Yes	hesis (Joints g? Yes _ of the follow s No s No s No	s, heart valve, etc)? I No Do you beco ving: Glaucoma Diabetes Cancer	f yes pleas ome breatl Yes _ Yes	se spec hless ea No No No	Heart murmur Emphysema Psychiatric care	Yes Yes Yes	N	
Have you had heart surgery? If the proof of	hesis (Joints 3? Yes _ of the follow s No s No s No s No	s, heart valve, etc)? I No Do you becoving: Glaucoma Diabetes Cancer Heart trouble	f yes pleas ome breath Yes _Yes _Yes	se spec hless ea No No No	Heart murmur Emphysema Psychiatric care Hiv/aids	Yes Yes Yes Yes	N N N	
Have you had heart surgery? If Do you have any artificial prostle Do you have abnormal bleeding Do you have or have had any out this blood pressureYes Sinus problemsYes Head or Neck injuriesYes Digestive disordersYes Sinus problemsYes Sinus problems	hesis (Joints g?Yes _ of the follow sNo sNo sNo sNo sNo	s, heart valve, etc)? I No Do you becoving: Glaucoma Diabetes Cancer Heart trouble Kidney trouble	f yes pleas ome breath Yes Yes Yes Yes	se spec hless ea No No No No No	Heart murmur Emphysema Psychiatric care Hiv/aids Osteoporosis	Yes Yes Yes Yes	N	
Have you had heart surgery? If Do you have any artificial prostly Do you have abnormal bleeding Do you have or have had any out the blood pressure and year of the blood pressure and year out the year ou	hesis (Joints g?Yes _ f the follow s No s No s No s No s No s No	s, heart valve, etc)? I No Do you becoving: Glaucoma Diabetes Cancer Heart trouble Kidney trouble Ulcer	Yes	se spec hless ea No No No No No	Heart murmur Emphysema Psychiatric care Hiv/aids Osteoporosis Anemia	Yes Yes Yes Yes Yes	N	
Have you had heart surgery? If Do you have any artificial prostle Do you have abnormal bleeding Do you have or have had any or have head or Neck injuries had	hesis (Joints g? Yes _ If the follow S No	s, heart valve, etc)? I No Do you becoving: Glaucoma Diabetes Cancer Heart trouble Kidney trouble Ulcer Hepatitis type	Yes	se spec hless ea No No No No No No No	Heart murmur Emphysema Psychiatric care Hiv/aids Osteoporosis Anemia Thyroid disease	Yes Yes Yes Yes Yes Yes	N	
Have you had heart surgery? If Do you have any artificial prostle Do you have abnormal bleeding Do you have or have had any outline High blood pressure	hesis (Joints Response Services (Joints Respon	s, heart valve, etc)? I No Do you becoving: Glaucoma Diabetes Cancer Heart trouble Kidney trouble Ulcer Hepatitis type Chest pain	Yes	se spec hless ea No No No No No No No	Heart murmur Emphysema Psychiatric care Hiv/aids Osteoporosis Anemia Thyroid disease Arthritis	Yes		
Have you had heart surgery? If Do you have any artificial prostle Do you have abnormal bleeding Do you have or have had any or High blood pressure Yes Sinus problems Yes Low blood pressure Yes Head or Neck injuries Yes Venereal Disease Yes Nervous problems Yes Radiation therapy Yes Alcohol/drug dependency Yes	hesis (Joints Resis (Joints R	s, heart valve, etc)? I No Do you becoving: Glaucoma Diabetes Cancer Heart trouble Kidney trouble Ulcer Hepatitis type Chest pain Blood disorders	Yes	No	Heart murmur	Yes Yes Yes Yes Yes Yes Yes Yes	N N N N N N N N N N N N N N N N N N N	
Have you had heart surgery? If Do you have any artificial prosts Do you have abnormal bleeding Do you have or have had any or high blood pressure Yes Sinus problems Yes Low blood pressure Yes Head or Neck injuries Yes Venereal Disease Yes Nervous problems Yes Radiation therapy Yes Alcohol/drug dependency Yes Tuberculosis Yes Yes Yes Yes Yes Yes Yes Yes Yes Ye	hesis (Joints g?Yes _ If the follow s No	s, heart valve, etc)? I No Do you becoving: Glaucoma Diabetes Cancer Heart trouble Kidney trouble Ulcer Hepatitis type Chest pain Blood disorders Liver disease	Yes	No	Heart murmur	Yes _	N N N N N N N N N N N N N N N N N N N	
Have you had heart surgery? If Do you have any artificial prosts Do you have abnormal bleeding Do you have or have had any or high blood pressure Yes Sinus problems Yes Low blood pressure Yes Low blood pressure Yes Venereal Disease Yes Nervous problems Yes Radiation therapy Yes Alcohol/drug dependency Yes Tuberculosis Yes Headaches Yes	hesis (Joints g?Yes _ If the follow s No	s, heart valve, etc)? I No Do you becoving: Glaucoma Diabetes Cancer Heart trouble Kidney trouble Ulcer Hepatitis type Chest pain Blood disorders	Yes	Se special spe	Heart murmur	Yes Yes Yes Yes Yes Yes Yes Yes		

Do you smoke? Yes No If so how much? Do you take recreational drugs? Yes No Women: Are you taking Birth Control Pills? Yes No Are you pregnant? Yes No										
This is to certify that I, the undersigned, consent to the performing or the procedures agreed to be necessary or advisable and I will assume responsibility for fees associated with those procedures.										
Signed:										
Account Information										
Person financially responsible for the account:										
Dental History										
Are you having any discomfort at this time? If yes please specify:										
Have you been under the regular care of a dentist?YesNo How long since your last dental visit:										
Do you currently experience any of the following?										
Loose teeth Yes No Ear ache Yes No Spaced or crooked teeth Yes No										
Bad Breath Yes No GaggingYesNo Unexplained nose bleedsYes No										
Missing Teeth Yes No Sore GumsYesNo Popping or clicking of the jawYes No										
Bleeding gumsYes No HeadacheYes No Unsatisfactory Dentures Yes No										
Office Policy										
Your appointment time will be reserved especially for you. If you are unable to keep your appointment we require 48 hours notice, otherwise, it may be necessary to charge for the time lost.										
understand that I am ultimately responsible for the total fees associated with the treatment performed.										
Date: Patient/ Guardian signature:										