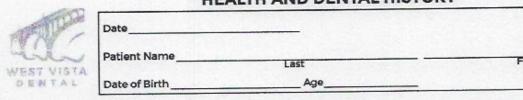
PATIENT INFORMATION FORM

PATIENT			HOW DID YO	U HEAR ABOUT US	72
Name			☐ Family/friends	☐ Newspaper	☐ Radio
Last	First		☐ Office sign	☐ Office transfer	☐ Yellow Pages
Address		Apt.#	☐ Billboard	☐ Our website	☐ Direct mall
			☐ Flyer/coupon	☐ Online search	☐ Online ad
City	Zip		☐ Insurance plan	OTV	
How long at this address	s?		Do you have family or t If so, please list name(s	friends who may need and relationship(s):	dental care?
Phone	Cell				
Email			Were you referred b	y anyone?	
			INSURANCE / DENT	TAL PLAN (PRIMARY)	
Social Security #			Plan Name		
Drivers License #			Address		
Age	Date of Birth		City		p
RESPONSIBLE PARTY (SKIP	P IF SAME AS ABOVE)		Insurance/Plan Phor	ne#	
Name			Insured's Name		
Last	First			Group#P	
Address		Apt#			
City	Zin		Insured SSN#	Date of Bir	ui
City			INSURANCE / DEN	TAL PLAN (SECONDA	ARY)
How long at this address	55?		Plan Name		
Relationship to patient					
SSN#			Address		
Age			City		ip
EMPLOYMENT			. Incurrence/ Disc Dho	one #	
Occupation			IIISQIAI (Ce) FIGIT FIX	5/10 1/	
			Insured's Name		
Employer		A CONTRACTOR OF THE PARTY OF TH	Union	Group# F	Plan#
Length of Employment				Date of Bi	
			1. I certify that the information	provided is accurate and will be	a used to grant credit and provid
Business Address			paid by my insurance for any s	eason. That you may verify and excha-	for all charges not covered by or nge information on me and any
City	Zij	P	additional applicants, including	g reports from credit reporting a	agencies. surance benefits otherwise paval
Business Phone	Ex	t	to me. I understand that I am authorization. I authorize relea	financially responsible for all cha use of any information relating to the practice is owned and operate	arges not covered by this o any dental claim(s). od by an independent dentist. I
EMERGENCY CONTACT			acknowledge that each clantic	t is individually responsible for tentity is responsible for my dent	he dental care provided to me a
Name					
Phone			Signature of Patient	or Responsible Party	Date
			(Parent if patient is a m	inor	

HEALTH AND DENTAL HISTORY



wash - /	Patient Name				
VEST VISTA		Last		First	
	Date of Birth		\ge		
EASON FOR VISIT					
ate of last visit to a	dentist	Treatme	nt performed		
Vas the treatment of	completed?	When w	vere dental x-rays tak	en?	
	ning? 🗆 Yes 🖽 No		Have you had per	iodontal (gum) treatmen	t? ☐ Yes ☐ No
	your smile? ☐ Yes ☐ No		Do you have miss	ing teeth? Yes No	
	after brushing/ flossing?			tures? Yes No	
	your dentures? Yes			oholic Beverages? Yes	□ No
		1110	50 103 5111117110		
Do you use tobacco					
PLEASE CHECK IF A	NY OF THE FOLLOWING			To a secondary	iaw clinching
	ast dental treatment		g after an extraction		
☐ Ear problems (inc	cluding popping, locking	, pain and click	ing)	Temporomandibular Join	nt Dystunction (IMJ)
Description					
MEDICAL INFORMA	ATION	ives places enc	oci6. Dr.h	Name	Phone
Description MEDICAL INFORMA Are you under a do	ATION ctor's care? Yes No If	yes, please spe	ecifyDr. t	Name	Phone
MEDICAL INFORMA Are you under a doo Are you allergic to p	ATION ctor's care? Yes No If Denicillin, local anesthetic	s, tranquilizers,	codeine or any othe	r medicine?	
MEDICAL INFORMA Are you under a doo	ATION ctor's care? Yes No If Denicillin, local anesthetic	s, tranquilizers,	codeine or any othe	Name r medicine? l, Aspirin? (If yes, specify) _	
MEDICAL INFORMA Are you under a do Are you allergic to p Are you currently ta	ATION ctor's care? Yes No If Denicillin, local anesthetic sking any medications (in	cs, tranquilizers, cl. Birth Contro	codeine or any othe I, Blood Thinners incl	r medicine?	
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Are you under a doc Are you allergic to p Are you currently ta Do you take Bispho Are you pregnant? Do you have any ot PLEASE CHECK IF Artificial heart AIDS/HIV Anemia Angina Arthritis Asthma	ctor's care? Yes No If penicillin, local anesthetic sking any medications (in sphinates? If so, how many months? Nouve HAD ANY OF THE Valve Chemo/rad Cosmetic sulpiabetes Dizziness or Drug addict Epilepsy	should be awar E FOLLOWING: therapy	codeine or any othe I, Blood Thinners incl The of? Heart surgery Heart problems Hepatitis High blood pressure Jaundice Joint replacement Kidney disease	Liver problems Low blood pressure Lung disease Pacemaker Phen-fen Rheumatic fever	Sleep apnea Smoking tobacco Stroke Thyroid problems TMD or TMJ Tuberculosis Venereal disease
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Date_ ___ Doctor Signature ___ Patient Signature _ Date Doctor Signature Patient Signature _