

Lives Change Here

Metal/Ceramic Braces Invisalign Teen/Full TMJ Therapy

Patient Information	*COMP	LETE BOTH S	IDES*	
Date				
Patient's Name	Last			
Address		First		Middle
Home Phone	Street Birthdate	City	Social Security #	State/Zip
If patient is a minor, give pare	nt's or guardian's name			
E-mail :		Cell Phone	e / Provider:	
Hobbies				
School			<i>«</i>	
Dentist	How	did you hear of our	office?	
Responsible Party Informatio	n			
			Driver's LIC#	Exp
Name	Last	First	Middle	Marital Status
Residence				
	Street	City		State/Zip
Mailing Address				
Ū	Street	City		State/Zip
Home Phone	Cell Phor	ie	Work Phone	
Previous address (if less than	3 years)			
Social Security #	Street	date	City Relationship to Patient	State/Zip
Employer				
Spouse's Name				
Employer	Addr		·	
Social Security #	Birth	date	Work Phone	
Dental Insurance Information				
Insured's Name			Insured's Soc. Sec. #	
Insurance Company				_ Local No
Insurance Co. Address				
*Insured's Employer				
Do you have dual coverage?		□ No	If yes:	
Insured's Name			-	
Insurance Company				
Insurance Co. Address			-	
*Insured's Employer				
Emergency Information				
Name of nearest relative not				
Phone		-		

Please complete	the following	(					
Is patient in g	ood health?					Yes	🔲 No
							🗆 No
				vo years?			🗖 No
If ves. for wh				- ,			
<b>j</b> = = , =		f heart trouble a	sthma kidney or liver in	nvolvement, allergy (seaso	anal or food) or	 2DV	
	ic disorders? If ye		Strind, Kidney of liver in	wolverheitt, allergy (seast		☐ Yes	🗆 No
			diabetes other?				No No
	e list drug and dos						
	-						
			-				-
	ested positive for	-	-			🗆 Yes	🗆 No
			I.I.V. PositiveA.I.I				🗆 No
	•						
Has patient e	experienced any u	unfavorable read	ction from any previous	dental treatment?		🛛 Yes	🗆 No
Date of last of	lental cleaning ex	kam:					
Have you use	ed any of these s	ubstances?					
E Fosama	x Actonel	Aredia	Zometa (Bisphosp	hates) 🔲 Corticostero	ds		
	<b>D</b> (	o N ·	0				
WOMEN Are you	:Pregnant	<pre>/Nursin</pre>	g <i>:</i>				
This medical Histo	orv is accurate an	d current as of					
			DATE	SIGNATURE			
What is your chief c	omplaint?						
Medical History U	odate: 1.	22	Initial & Date Initial	& Date			
	Initial	a Dale		ע שמול			
Consent							
Consent							
I consent for x-	ravs and an o	ral evaluation	h by the doctor.				
			dit bureau reports r	nav be obtained.			
				dates by email or tex	ŀ		
				-			
Signature (Pare	ent's signature	e if minor) —					
Dr. Signature			Date:	l Indata 1		Lindata 2	
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FOR OFFICE	JSE ONLY :				<u></u>		
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