Welcome To help us completely in in

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 #
Destinant To Comment		SS#/SIN
Patient Information	Date	
Name		Home Phone
Address	City	Home Phone Zip/ State/ Zip/ Prov. P.C.
Email		Cell Phone
Check Appropriate Box: $\square$ Minor $\square$ Single		□ Widowed □ Separated
If Student, Name of School/College	City	State/ Full Part Prov ☐ Time ☐ Time
Patient or Parent/Guardian's Employer		Work Phone
Patient or Parent/Guardian's EmployerAddress	City	Prov. P.C.
Spouse or Parent/Guardian's Name	Employer	Work Phone
Whom may we thank for referring you?	- N	di Phi vino
Person to contact in case of emergency		Phone
Responsible Party		
Name of Person Responsible for this Account		Relationship to Patient
Address		Home Phone
Email		
Driver's License #		
Employer		
Insurance Information	i	I wish to discuss the office's payment policy. Relationship
Name of Insured	7.50	to Patient
BirthdateSS#/SI		
Name of Employer	Union or Local #	Work Phone
Address of Employer	City	Prov P.C
Insurance C( mpany	Group #	Policy/ID #
Ins. Co. Add ess	City	Prov Pr. C
How much is your deductible?	_ How much have you used?	Max. annual benefit
DO YOU HAVE ANY ADDITIONAL INSURANC	E?	, COMPLETE THE FOLLOWING:
Name of Inst red	11 - 11 y _ a 11 - 11	Relationship to Patient
Birthdate \$\$#/\$IN	V	Date Employed
Name of Employer	Union or Local #	Work Phone
BirthdateSS#/5IN Name of EmployerAddress of Employer	City	State/ Zip/ Prov. P.C.
Insurance Company	Group #	
ns. Co. Address		State( Tim/
How much is your deductible?		Max annual honofit

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2. History one core han hospitalistical for any angle allowands or scrottes affects such as the last 5 years?		,	Yes					·	Yes	_
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A seem taking an marketainan ()    A seem taking an marketainan ()   multiming maney seempron marketain ()   multiming maney s	— surgical operation or serious illness within the last 5 years?	·			Lı	cul An	estheti	ics (e.g. Novocain)	🗆	
3 Are year testing on year feet control   Supplement	If yes, please explain				$P_{t}$	nicillin	or an	ry other Antibiotics		
Sectiones	3. Are you taking any medication(s)				St	lfa Dn	ugs		🖳	
June successfunction of your year aching?	including non-prescription medicine?				Se	umuure datives	::::::::::::::::::::::::::::::::::::::		-	
4. How you core to blook ten-Plankfacines?	If yes, what medication(s) are you taking?				lo	dine			<u> </u>	
5. How you cere in their issuance, Bennie, Aerone or any concer mechacitors contemp (polipolaphenia).  6. Hide you facken Viogra, Routin. Civilia or Lexitira in the fast 24 his 192.  7. Do you me fabrica?  9. Droyon have or viare you had any of the following?  9. Droyon have or viare you had any of the following?  9. Droyon have or viare you had any of the following?  10. Are you merified substances?  9. Droyon have or viare you had any of the following?  10. Are you marring?  10. Are you were marring?  10. Are you were marring?  10. Are you were marring?  10. Are you were marring?  11. How you were marring?  12. Are you were marring?  13. Are you were failed while Impairing or flessing?  14. Droy you were marring?  15. How you warring?  16. Droy on wellow of you were failed?  17. How you were marring?  18. How you were marring?  19. Droy on weelend. Yet great you wer			1")	ıı	$\Lambda$ s	pirin	· · · · · · · · · · · · · · · · · · ·		🔲	
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6. Now you techn Vageus, Revotic, Guilst or Lessing in the last 24 but 10.57  7. Do you we do he was 25  8. Do you we control substants 37  9. Du you have or nine you had any of the following?  9. Du you have or nine you had any of the following?  1. Heart Antack  1. Heart Disease  1. Heart Antack  1. Heart Misses  1. Heart	medications containing bisphosphorates?			[.]	0	ther (pi	lease li	ist)	!	
associated with a horsen illuses (lesting more than 3 weels)   g. Dr. you in the charters   g. Dr. you in the charters   g. Dr. you have or nate you had any of the following?   d. Are you missing?	6. Flave you taken Viagra, Revatio, Cialis or Levitra			_	12. Da	you ha	ive a pe	ersistent cough or throat clearing not		
8. Do you new controlled substances?     al Arr you preguent or blinky our map be preguent?       9. Dryon have ar increased all arry of the following?   O Arr you tristing?   O Arry you tristing?   O Arry you tristing or all contraceptives?     1 High Hand Arryon   Chest Hairs   C	7. Do you use tobacco?		H		us:	rociated	with a	a known illness (lasting more than 3 weeks)? .	🗀	
9. Do you have or have you had any of the following?    Char you to foling and contraceptoes?.	8. Do you use controlled substances?			ä				mant or think you may be preamant?	г	
Combined Pressure			_		b)	Are yo	u nurs	sing?	🗆	
High Blad Poesam					c)	Are yo	u takir	ng oral contraceptives?	. 🗀	
Hour Atlack										V.
Stroke								Chest Pains		
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Aschina	Fainting / Seigures	iently Tir	red	.,,,,,,,,,,				Tuberculosis		=
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cancer   Can		увста			• • • • • • • • • • • • • • • • • • • •			Glaucoma	. 🗀	
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Respiratory Problems   Respiratory Problems   Respiratory Problems   Respiratory Problems   Respiratory Problems   Respiratory Respiratory Problems   Respiratory Respirator		uus Dankana		i		. 📙		Liver Disease	🔲	=
ADS or HIV Injection   Sexually Transmitted Disease   Mitral Valve Prolapse   Patient Dental History  Name of Previous Dentis and Location   Date of Last Exam   Yes No   B. Do you have frequent headaches?   Sexually Transmitted Disease   Provious Dentis and Location   Yes No   B. Do you have frequent headaches?   Sexually Transmitted Disease   Provious Dentis and Location   Yes No   Do you have frequent headaches?   Sexually Transmitted Disease   Provious Dentis and Location   Yes No   Do you have frequent headaches?   Sexually Disease   Do you have frequent headaches?   Sexually Disease   Do you have frequent headaches?   Sexually Disease   Do you clench or grind your teeth?   Do you get pain to any of your teeth?   Do you get pain to any of your teeth?   Do you get pain to any of your teeth?   Do you know any sores or lumps in or near your mouth?   Do you have any sores or lumps in or near your mouth?   Do you have gray prolonged bleeding following extractions?   Do you know any sores or lumps in or near your mouth?   Do you want dentures or partials?   Do you know any sores or lumps in or near your mouth?   Do you want dentures or partials?   Do you know any sores or lumps in or near your mouth?   Do you want dentures or partials?   Do you know any prolonged bleeding following extractions?   Do you know any prolonged bleeding following extractions or season and provide to any prolonged bleeding following extractions or season and provide to any prolonged bleeding following extractions or partials?   Do you know dependent to any prolonged bleeding following extractions or prolonged bleeding follow		ritis / lan	nera oi mdice	impa	m(	$\vdash$				
Patient Dental History  Name of Previous Dentist and Location    Dute of Last Exam	AIDS or HIV Injection	ally Trans	smitted	l Disec	(5¢		[****]	Mitrul Valve Prolanse	님	,:=
Patient Dental History  Name of Previous Sentist and Location    Dute of Last Exam   Yes	Thyroid Problem Storne	ach Trou	bles / l	Ilcers ,				Other	<u> </u>	
Name of Previous Dentist and Location	Patient Dental History								_	
Loo your gams bleed while brushing or flossing?								Data of Last France		
2. Are your teeth se estive to hot or cold liquids/foods?		١.	ine i	 No				Date of Last Exam	V	<b>-</b> _
3. Ave your teeth se sative to sweet or sour liquids/foods?       0. Do you bite your lips or cheeks frequently?       4. Do you feel pain to any of your weth?       11. Have you ever had any difficult extractions in the past?       11. Have you ever had any prolonged bleeding following servactions?	1. Do your gams bleed while brashing or flossing?	[			8. D	you h	ave fre	equent headaches?	ies .	7
4. Do you leave any sores or lumps in or near your mouth?	2. Are your teeth se isitive to hot or cold liquids/foods?	[			9. D	уон а	lench c	or grind your teeth?	. 🗀	- ξ
5. Bo you have any sores or lumps in or near your mouth?	5. Are your teem so islave to sweet or sour liquids/Joods?	L			10. Da	you b	ite you	ir lips or cheeks frequently?	. 🗀	Ē
6. Have you had any head, neck or jaw injuries?	5. Do you have any sores or lumps in or near your month?	L	=		11. Ha	ive you	ever h	uad any difficult extractions		
7. Have you ever ex-serienced any of the following problems in your jaw?   13. Have you had any orthodontic treatment?	6. Have you had any head, nech or law injuries?	[	╡	Ħ					. Ц	_
13. Have you had any orthodontic treatment?	7. Have you ever experienced any of the following		_							;-
Pain (joint, ea; side of face)   14. Do you wear dentures or partials?   Pain (joint, ea; side of face)   15. Have you ever received oral hygiene instructions   15. Have you ever received oral hygiene instructions   16. Do you like your smile?					13. Ho	ive you	had a	iny orthodontic treatment?		=
Difficulty in opening or closing	Clicking	[			14. Do	you w	ear de	entures or partials?		· `;=
Difficulty in clewing	Difficulty in opening or closing		╣ ;		lf y	res, dut	e of pl	lacement		
Authorization and Release  I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answell understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party protherwise payable to me. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits for payament of all services rendered on my hehalf or my dependents.  X  Signature of patient (or parent/guardian if minor)  Date  Doctor's Comments	Difficulty in clewing	L	-	₹	15. Flo	ive you	ever n	received oral hygiene instructions	_	
Authorization and Release  I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answed all understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including analytic health providing incorrect information rendered to me or my child during the period of such Dental care to third party provided in the provided provided insurance company to pay directly to the dentist or dental group insurance benefits for payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my hehalf or my dependents.  **Signature of patient (or parent/guardian if minor)**  Date  Doctor's Comments  Doctor's Comments			_ '	_	16. Da	saraing vou li	ke vou	re of your teeth and gums?	片	-
I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answel understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party problems. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits of the dentist or dental group insurance benefits for payment of all services rendered on my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible to payment of all services rendered on my hehalf or my dependents.  **X**  **Signature of putient (or parent/guardian if minor)**  **Date**  **Doctor's Comments**  **Doctor's Comments**	Authorization and Dalas	**				,,	- 7			l.,
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otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible to the payment of all services rendered on my behalf or my dependents.  X  Signature of patient (or parent/guardian if minor)  Date  Doctor's Comments	diagnosis and the records of any treatment or examination	and designed a	or the later	,	Julian I	1417	tze chi	e dentist to release any information i	nciudi	$n$ , $\epsilon n$
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Signature of patient (or parent/guardian if minor)  Date  Doctor's Comments	for payment of all services rendered on my behalf or my d	lepender	its.	rmay	pay tess	tnan	the ac	ctual bill for services. I agree to be re	sponsi	ble
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## Patient Acknowledgment of Receipt of Notice of Privacy Practices

lease Print	
·	, hereby acknowledge that I have reviewed and received a cop
f this office's Novice of Privacy Practices explain	ning;
How this office will use and disclose n	ny protected health information.
My privacy rights with regard to my p	protected health information.
■ This office's obligations concerning the	e use and disclosure of my protected health information.
understand that the <i>Notice of Privacy Practice</i> : <i>lotice of Privacy Practices</i> upon request.	s may be revised from time to time and that I am entitled to receive a copy of any revised
also understand that if I have any questions or	r complaints, I may contact:
	71b
	7/8 h a.u.
ou may also contact the Secretary of the U.S. De	epartment of Health and Human Services with any concerns regarding our privacy and security
ou may also contact the Secretary of the U.S. De olicies and procedures. Please contact our office Patient or Personal Representative gnature;	e for information on how to contact the U.S. Department of Health and Human Services.
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Patient or Personal Representative gnature:  Please Frim  Clationship to Patient:  For Office Use Only  We made a good-faith effort to obtain a receipt of our Notice of Privacy Practice acknowledgment of receipt for the follows:	an acknowledgment of





## Patient Consent & Authorization for Release of Protected Health Information

Patient Name: _				Date of Birth:
Address:				
City:	S	tate: ZIP Code:	Telephon	e Number:
E-mail Address:		1 C 3 HH 1		il Ne
Patient Au	thorization			
I.		, hereby authorize the	release, use or disclosure of	my health information as follows:
	ation pertains to the following ty	·		
I hereby author	orize	Name of individual(s) and/	or organization providing informa	ition
to release the	above-described information to	Name of in	dividual(e) and (or organization ro	salving this information
I understand to information for	that, per my request, this authorizator purposes beyond treatment, payability Act of 1996 (HIPAA).	tion will permit the abo	ove-named parties to use or	disclose the identified health
I understand t	that I may revoke this authorization	at any time by providi		
revocation doe	n will be effective on the date it has so not apply to actions taken in relia nove to sign this authorization in or	been received and pro nce upon this authoriza	cessed by the above-named tion prior to the effective dat	e of revocation. I also understand
Unless I reque	st in writing otherwise, I understan	d that this authorizatio	n will expire on	. If I do not
	ication date or event, this authoriza			
I understand t recipient, and	that the information used or disclos may no longer be protected by HII	ed pursuant to this aut 'A.A's privacy rules afte	chorization may be subject to r the authorized disclosure.	o redisclosure by the named
Patient or l	Personal Representative			11111
lignature:				Date:/_/
Varme:Please				
	Patient:			
For O	ffice Use Only			
Receive	ed by:	# M		Date:/



This product is designed to provide accurate and authoritative information. However, it is not a substitute for legal advice and does not provide legal opinions on any specific facts or services.

The information is provided with the understanding that any person or entity involved in creating, producing or distributing this product is not liable for any damages arising out of the use or inability to use this product. You are urged to consult an attorney concerning your particular situation and any specific questions or concerns you may have.