DENTAL REGISTRATION AND HISTORY

	NFORMATI	ON	D	ENT	AL INSURANCE		_
Date			W	ho is res	ponsible for this account?		
SS/HIC/Patient ID #		R	elationship	o to Patie	ent		
Patient Name		In	surance C	20.			
Last Name		G	roup #				
First Name		A ALL A WILLIAM TO			y additional insurance? Yes	T No.	
Address			ubscriber'				
-mail			2002/10/2019	NAME OF THE OWNER, OWNE	SS#		
City							
State			and the same of		ent		
ex DM DF Age		22		24.0			
		30	TO A STORY	market to	WALL (428)		
Sirthdate		1	ssignment certify that		ELEASE /or my dependent(s), have insuran	ce coverag	e w
☐ Married ☐ Widowe		ACT NAME OF THE OWNER.			and	assign direc	ctly to
Separated Divorce	d Partnered	for years	N	lame of In	surance Company(ies)		
atient Employer/School					all in		
Occupation		fin	nancially res	sponsible	for all charges whether or not paid by in		
mployer/School Address				Production	e on all insurance submissions.		
		su	uch informa	tion to the	tist may use my health care information above-named Insurance Company(ie	s) and their	ager
Employer/School Phone (for			taining payment for services and dete s payable for related services. This con		
pouse's Name			y current tr	eatment p	lan is completed or one year from the o	date signed t	belov
Sirthdate			Plane	turn of Do	tient, Parent, Guardian or Personal Rep	annontation	
THE RESIDENCE TO SERVICE TO SERVI			Oligina	interol ca	nein, Parein, Guardian of Personal Ney	DI GOGGINGTOAG	
928							
SS#			Please pri	nt name o	of Patient, Parent, Guardian or Personal	Representa	ative
Spouse's Employer			Please pri	ACCOUNTS OF		Name and	ative
			Please pri	nt name o	of Patient, Parent, Guardian or Personal Relationship to	Name and	ative
Spouse's Employer Whom may we thank for refe	rring you?		Please pri	ACCOUNTS OF		Name and	ative
Spouse's Employer	rring you?		Please pri	ACCOUNTS OF		Name and	ative
Spouse's Employer Whom may we thank for refe	rring you?			ACCOUNTS OF		Name and	stive
PHONE NU	rring you?	Work ()		Date	Relationship t	Name and	ative
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PHONE NU Phone () Spouse's Work () N CASE OF EMERGENCY, Name Home Phone () DENTAL H Reason for today's v City/State Date of last dental visit Date of last dental X-rays Place a mark on "yes" or "no have had any of the following	TISTORY "to indicate if you	Work () Best time and place to reach you someone who does not live in you Relati Work Burning sensation on tongue Chew on one side of mouth Cigarette, pipe, or cigar smoking Clicking or popping jaw Dry mouth Fingernail biting Food collection between the teeth Foreign objects Grinding teeth Gums swollen or tender	ur househ ionship _ Phone (_ Yes Yes Yes Yes Yes Yes Yes Yes Yes	Date Ext old.) No	Mouth breathing Mouth pain, brushing Orthodontic treatment Pain around ear Periodontal treatment Sensitivity to cold Sensitivity to heat Sensitivity to sweets	O Patient O Patient O Yes [
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Physician's Name						Date of last visit		
	enhanata	madication	2 Common hand names	are Eccamay /	Atonal Ato	elvia, Didronel, Boniva. Yes	□No	
and the work of the second	No.						73	
names of phentermine), Pond	fimin (fen	fluramine) a	and Redux (dexfenfluramin	e). 🗆 Yes 🗆	No No	mbinations of Ionimin, Adipex, Fa	astin (brar	nd
Place a mark on "yes" or "no"		Lamina a sali		Anna Common	PT No.	Description Disease	- TW-	
AIDS/HIV	☐ Yes	□ No	Epilepsy	Yes		Respiratory Disease	Yes	□ N
Anemia	Yes	□ No	Fainting or dizziness	Yes	□ No	Rheumatic Fever	☐ Yes	
Arthritis, Rheumatism	Yes	□ No	Glaucoma	Yes	□ No	Scarlet Fever	Yes	
Artificial Heart Valves	Yes	□ No	Headaches	Yes	□ No	Shortness of Breath	Yes	
Artificial Joints Asthma	Yes	□No	Heart Murmur	Yes	□ No	Sinus Trouble	☐ Yes	
	Yes	□ No	Heart Problems	☐ Yes	□ No	Skin Rash	☐ Yes	
Back Problems	Yes	□ No	Hepatitis Type	Yes	□ No	Special Diet	☐ Yes	
Bleeding abnormally, with extractions or surgery	Yes	□No	Herpes	Yes	□ No	Stroke	Yes	□ N
Blood Disease	Yes	□No	High Blood Pressure	Yes	□ No	Swollen Feet or Ankles	Yes	
Cancer	□Yes	□No	Jaundice Jaundice	Yes	□ No	Swollen Neck Glands	☐ Yes	
Chemical Dependency	Yes	□No	Jaw Pain	☐ Yes	□ No	Thyroid Problems	☐ Yes	
Chemotherapy	□Yes	□No	Kidney Disease	☐ Yes	□ No	Tonsillitis Tuberrulesia	Yes	
Circulatory Problems	Yes	□No	Liver Disease	Yes	□ No	Tuberculosis	☐ Yes	
Congenital Heart Lesions	☐Yes	□No	Low Blood Pressure	Yes	□ No	Tumor or growth on head or neck	Yes	
Cortisone Treatments	☐ Yes	□No	Mitral Valve Prolapse Nervous Problems	☐ Yes	□ No	Ulcer	Yes	ΠN
Cough, persistent or bloody	☐Yes	□No	THE RESERVE TO STREET STREET	☐ Yes	□ No	Venereal Disease	Yes	DN
Diabetes	□Yes	□No	Pacemaker Com-	Yes	□ No	Weight Loss, unexplained	☐ Yes	□ N
Emphysema	Yes	□No	Psychiatric Care	Yes	□ No	rreigin 2000, urexplained	П 103	ш,
Do you wear contact lenses?	☐ Yes	□ No	Radiation Treatment	Yes	□ No			
Are you pregnant? Yes Taking birth control pills? MEI	2000 0	No TIONS	Due date		Are you nu	rsing? Yes No ALLERGIES		
Taking birth control pills?	Yes [No TIONS	discone - Ti		Are you nu	rsing? Yes No ALLERGIES		
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