CONFIDENTIAL PATIENT HISTORY

CONFIDENTIAL PATIENT HISTORY			Date			
Name			Prefers to be called			
Last	First	M.I.				
Complete Mailing	Address		zip			
Employer / Addre	ess		zip			
Birth Date			Home phone			
Social Security #			Work phone			
	11 (11 12 24)		Cell phone			
Whom may we the	ank for referr	ing you?				

Name	Cell Phone
Relationship to patient	Work Phone
	zip
Birth Date	
Social Security #	
If patient is a full time student, what is the nai	me of the school?
Grade City and State	

Do you now have, or have you ever had any of the following? Please check the appropriate boxes.

УN	Description Date YN Descrip		Description	Date	
0 0	Heart Disease/Surgery		0 0	HIV Positive, ARC, or AIDS	
0	Heart Murmur		0 0	Hepatitis (circle) A, B, or C	
0	Mitral Valve Prolapse		0 0	Chemical Dependency	
0	Heart Attack/Failure		0 0	Diabetes	
0 0	Artificial Joint/ Heart Valve		0 0	Tuberculosis	
0 0	Abnormal Blood Pressure		0 0	Emphysema	
0 0	Stroke		0 0	Asthma	
0 0	Blood Clotting Disorder		0 0	Eating Disorder	
0 0	Cancer	la i	0 0	Frequent Cough	10 74 6
0 0	Radiation Treatment		0 0	Cold Sores / Fever Blisters	
0 0	Chemotherapy		0 0	Epilepsy / Seizures	
0 0	Recent Blood Transfusion	1 18 - 18 -	0 0	Fainting / Dizziness	
0 0	Traumatic Accident		0 0	Pacemaker	T. 16 W. 1
0 0	Rheumatic Fever		0 0	Headaches	
0 0	Arthritis / Sore Joints		0 0	GERD/Acid Reflux	

Have you ever	had any other	serious illness no	t checked above?	If so,	discuss:	

Are you currently taking any drugs or medication? Please list the medication and its purpose. Are you allergic to any drugs, medications, or latex rubber? Please list: Have you been hospitalized or undergone major surgery in the past five years? Y/N If so please give details and dates: Women: Do any of the following apply? Pregnant? (due date: / /) Trying to conceive? Nursing? Primary reason for visit: For what reason do you usually come to the dentist? Have you ever had any serious problems associated with previous dental treatment? Y/N If so, please explain: Have you ever been diagnosed or treated for periodontal (gum) disease? Y/N Are you ever been diagnosed or treated for periodontal (gum) disease? Y/N Are there any swellings, growths, inflamed areas, or unhealed injuries in or around your mouth? Y/N Do you feel sensitivity with any of your teeth when brushing or flossing them? Y/N Are there any swellings, growths, inflamed areas, or unhealed injuries in or around your mouth? Y/N Does food catch between your teeth? Where: Is any part of your mouth sensitive to temperatures, biting pressure, or sweets? Y/N Have you had orthodontic treatment or bite adjustments? Y/N Do you have unreplaced missing teeth? Have you noticed any movement, shifting, or change in your teeth? Have you noticed any movement, shifting, or change in your teeth? Y/N Y/N Do you awaken with the awareness of your teeth and jaws? Y/N Do you awaken with the awareness of your teeth and jaws? Y/N Do you clench or grind your teeth during the day or night? Y/N Do you do any pain around your eyes, ears, nose, neck, or mouth? Y/N Y/N Do you have any pain around your eyes, ears, nose, neck, or mouth? Y/N Do you have a history of extensive dental treatment? Neckaches? Do you have a history of extensive dental treatment? P/N Has it been due to: onew cavities or gum disease or replacement of dental work Do you want to keep your remaining teeth?	Physician name and phone:	1000					
Please list the medication and its purpose. Are you allergic to any drugs, medications, or latex rubber? Please list: Have you been hospitalized or undergone major surgery in the past five years? Y/N If so please give details and dates: Women: Do any of the following apply? a Pregnant? (due date: _/	Have you ever been instructed to take antibiotics before any dental or surgical procedure? Are you currently taking any drugs or medication?						
Are you allergic to any drugs, medications, or latex rubber? Please list: Have you been hospitalized or undergone major surgery in the past five years? Y/N If so please give details and dates: Women: Do any of the following apply? Pregnant? (due date: When was your last dental visit: For what reason do you usually come to the dentist? Have you ever had any serious problems associated with previous dental treatment? Y/N If so, please explain: Have you ever been diagnosed or treated for periodontal (gum) disease? Y/N Have you been concerned about bad breath, unpleasant odor or taste in your mouth? Y/N Are there any swellings, growths, inflamed areas, or unhealed injuries in or around your mouth? Does food catch between your teeth when brushing or flossing them? Y/N Are there any swellings, growths, inflamed areas, or unhealed injuries in or around your mouth? Does food catch between your teeth? Y/N Have you had orthodontic treatment or bite adjustments? Y/N Have you have unreplaced missing teeth? Y/N If so, why have you chosen not to replace them? Have you noticed any movement, shifting, or change in your teeth? Have you had locking or clicking in your jaw, inability to open wide or chew tough foods? Y/N Do you awken with the awareness of your teeth and jaws? Do you awken with the awareness of your teeth and jaws? No you have any pain around your eyes, ears, nose, neck, or mouth? Y/N Do you have a history of extensive dental treatment? Has it been due to: a new cavities a gum disease Do you have a history of extensive dental treatment? No you have a history of extensive dental treatment? Has it been due to: a new cavities a gum disease Do you have a history of extensive dental treatment? No worthen do you get headaches? Do you award the keep your remaining teeth? Y/N Please add anything you feel important: Name and phone number of someone not living with you to contact in case of emergency Authorization Name and phone number of someone not living with you do contact in							
Have you been hospitalized or undergone major surgery in the past five years? If so please give details and dates: Whomen: Do any of the following apply? "Pregnant? (due date:/_) "Trying to conceive? "Nursing? Primary reason for visit:	Please list the medication and its purpose.	-					
If so please give details and dates: Women: Do any of the following apply? Pregnant? (due date:/) a Trying to conceive? aNursing? Primary reason for visit:	Are you allergic to any drugs, medications, or latex rubber? Please list:						
If so please give details and dates: Women: Do any of the following apply? Pregnant? (due date:/) a Trying to conceive? aNursing? Primary reason for visit:							
Primary reason for visit:	If so please give details and dates:						
For what reason do you usually come to the dentist? Have you ever had any serious problems associated with previous dental treatment? If so, please explain: Have you ever been diagnosed or treated for periodontal (gum) disease? Y/N Have you been concerned about bad breath, unpleasant odor or taste in your mouth? Y/N Do you feel sensitivity with any of your teeth when brushing or flossing them? Y/N Do you feel sensitivity with any of your teeth when brushing or flossing them? Y/N Does food catch between your teeth? Where: Is any part of your mouth sensitive to temperatures, biting pressure, or sweets? Y/N Have you had orthodontic treatment or bite adjustments? Y/N Do you have unreplaced missing teeth? If so, why have you chosen not to replace them? Have you noticed any movement, shifting, or change in your teeth? Have you noticed any movement, shifting, or change in your teeth? Have you had locking or clicking in your jaw, inability to open wide or chew tough foods? Y/N Do you have any pain around your eyes, ears, nose, neck, or mouth? If so, where & how often? How often do you get headaches? Do you have a history of extensive dental treatment? Has it been due to: a new cavities a gum disease Do you want to keep your remaining teeth? Neas it been due to: a new cavities a gum disease Do you want to keep your remaining teeth? Name and phone number of someone not living with you to contact in case of emergency. Authorization I understand that I am responsible for all costs of dental treatment. Payment is due at the time of services. The information on this page and the dental/medical histories are correct to the best of my knowledge. I hereby authorize the Dental Office to administer such medications and perform I understand that I am responsible for all costs of dental treatment. Payment is due at the time of services. The information on this page and the dental/medical histories and three pottices privacy policies have been mode directly to the Dental Office and irreatment to the	Women: Do any of the following apply? Pregnant? (due date: / /) Trying to conceive?	Nursing?					
Have you ever had any serious problems associated with previous dental treatment? If so, please explain: Have you ever been diagnosed or treated for periodontal (gum) disease? Y/N Have you been concerned about bad breath, unpleasant odor or taste in your mouth? Y/N Do you feel sensitivity with any of your teeth when brushing or flossing them? Y/N Are there any swellings, growths, inflamed areas, or unhealed injuries in or around your mouth? Does food catch between your teeth? Where: Is any part of your mouth sensitive to temperatures, bitting pressure, or sweets? Y/N Have you had orthodontic treatment or bite adjustments? Y/N Do you have unreplaced missing teeth? If so, why have you chosen not to replace them? Have you noticed any movement, shifting, or change in your teeth? Y/N Have you had locking or clicking in your jaw, inability to open wide or chew tough foods? Y/N Do you awaken with the awareness of your teeth and jaws? Y/N Do you lench or grind your teeth during the day or night? Y/N Do you have any pain around your eyes, ears, nose, neck, or mouth? If so, where & how often? How often do you get headaches? Neckaches? Neckaches? Do you have a history of extensive dental treatment? How at head to: a new cavities a gum disease replacement of dental work Do you want to keep your remaining teeth? Name and phone number of someone not living with you to contact in case of emergency Authorization I understand that I am responsible for all costs of dental treatment. Payment is due at the time of services. The information on this page and the dental/maction that I am responsible for all costs of dental treatment. Payment is due at the time of services. The information on this page and the dental/maction to the dentist to release my dental/mactical histories are correct to the best of my knowledge. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapetic procedures or may be necessary for proper dental care. I hereby authorize payment o	Primary reason for visit: When was your last dental visit	h:					
If so, please explain: Have you ever been diagnosed or treated for periodontal (gum) disease? Have you been concerned about bad breath, unpleasant odor or taste in your mouth? Do you feel sensitivity with any of your teeth when brushing or flossing them? Y/N Are there any swellings, growths, inflamed areas, or unhealed injuries in or around your mouth? Y/N Does food catch between your teeth? Where: Is any part of your mouth sensitive to temperatures, biting pressure, or sweets? Y/N Have you had orthodontic treatment or bite adjustments? Y/N Do you have unreplaced missing teeth? If so, why have you chosen not to replace them? Have you noticed any movement, shifting, or change in your teeth? Have you had locking or clicking in your jaw, inability to open wide or chew tough foods? Y/N Do you awaken with the awareness of your teeth and jaws? Do you lench or grind your teeth during the day or night? Y/N If so, where & how often? How often do you get headaches? Neckaches? Do you have a history of extensive dental treatment? How often do you get headaches? Do you have a history of extensive dental treatment? Hos if been due to: new cavities no gum disease replacement of dental work Do you want to keep your remaining teeth? Name and phone number of someone not living with you to contact in case of emergency Authorization I understand that I am responsible for all costs of dental treatment. Poyment is due at the time of services. The information on this page and the dental/medical histories are correct to the best of my knowledge. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therspectic procedures at may be necessary for proper dental care. I hereby authorize payment of insurance benefits to be made directly to the Dental Office of the revise poyable to me. A copy of the dental materials fact sheet and the office privacy policies have been made directly to the Dental Office of the rivise poyable to me. A copy of the dental materials fac	For what reason do you usually come to the dentist?	<u> </u>					
Have you ever been diagnosed or treated for periodontal (gum) disease? Y/N Have you been concerned about bad breath, unpleasant odor or taste in your mouth? Y/N Do you feel sensitivity with any of your teeth when brushing or flossing them? Y/N Are there any swellings, growths, inflamed areas, or unhealed injuries in or around your mouth? Y/N Does food catch between your teeth? Where: Is any part of your mouth sensitive to temperatures, biting pressure, or sweets? Y/N Have you had orthodontic treatment or bite adjustments? Y/N Do you have unreplaced missing teeth? If so, why have you chosen not to replace them? Have you noticed any movement, shifting, or change in your teeth? Y/N Have you had locking or clicking in your jaw, inability to open wide or chew tough foods? Y/N Do you wanken with the awareness of your teeth and jaws? Y/N Do you dave any pain around your eyes, ears, nose, neck, or mouth? Y/N Do you have any pain around your eyes, ears, nose, neck, or mouth? Y/N Has it been due to: onew cavities of your disease or replacement of dental work Do you want to keep your remaining teeth? Neckaches? Do you want to keep your remaining teeth? Name and phone number of someone not living with you to contact in case of emergency Authorization Name and phone number of someone not living with you to contact in case of emergency Authorization Name and phone number of someone not living with you to contact in case of emergency Authorization Name and phone number of someone not living with you to contact in case of emergency Authorization Name and phone number of of dental treatment. Poyment is due at the time of services. The information on this page and the dental/medical histories are correct to the best of my knowledge. I hereby authorize the bental Office to administer such medications and perform such diagnostic and therepeutic procedures as may be necessary for proper dental care. I hereby authorize payment of insuance benefits to be made directly to the botel Office of thervise paywhelp	Have you ever had any serious problems associated with previous dental treatment?	Y/N					
Have you been concerned about bad breath, unpleasant odor or taste in your mouth? Do you feel sensitivity with any of your teeth when brushing or flossing them? Y/N Does food catch between your teeth? Where: Is any part of your mouth sensitive to temperatures, biting pressure, or sweets? Y/N Have you had orthodontic treatment or bite adjustments? Y/N Do you have unreplaced missing teeth? If so, why have you chosen not to replace them? Have you noticed any movement, shifting, or change in your teeth? Y/N Do you danden with the awareness of your teeth and jaws? Y/N Do you dench or grind your teeth during the day or night? Y/N Do you have any pain around your eyes, ears, nose, neck, or mouth? If so, where & how often? How often do you get headaches? Do you have a history of extensive dental treatment? How often do you get headaches? Do you want to keep your remaining teeth? Neckaches? Do you want to keep your remaining teeth? Nas it been due to: " new cavities " gum disease " replacement of dental work Do you want to keep your remaining teeth? Name and phone number of someone not living with you to contact in case of emergency. Authorization I understand that I am responsible for all costs of dental treatment. Payment is due at the time of services. The information on this page and the dental/medical histories are correct to the best of my knowledge. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I hereby authorize payment of insurance benefits to be made directly to the Dental Office otherwise payable to me. A copy of the dental materials foct sheet and the office's privacy policies have been made available to me. I grant the right to the dentist to release my dental/medical histories and other information and my dental treatment to third parry and/or other health professionals. I understand that if I am unable to keep this appointment I will give a minimum of 48 hour	If so, please explain:						
Do you feel sensitivity with any of your teeth when brushing or flossing them? Are there any swellings, growths, inflamed areas, or unhealed injuries in or around your mouth? Does food catch between your teeth? Where: Is any part of your mouth sensitive to temperatures, biting pressure, or sweets? Y/N Have you had orthodontic treatment or bite adjustments? Y/N Do you have unreplaced missing teeth? If so, why have you chosen not to replace them? Have you noticed any movement, shifting, or change in your teeth? Have you nad locking or clicking in your jaw, inability to open wide or chew tough foods? Y/N Do you awaken with the awareness of your teeth and jaws? Y/N Do you awaken with the awareness of your teeth and jaws? Y/N Do you have any pain around your eyes, ears, nose, neck, or mouth? If so, where & how often? How often do you get headaches? Do you have a history of extensive dental treatment? Hos it been due to: a new cavities a gum disease replacement of dental work Do you want to keep your remaining teeth? Neckaches? Y/N Please add anything you feel important: Name and phone number of someone not living with you to contact in case of emergency. Authorization I understand that I am responsible for all costs of dental treatment. Payment is due at the time of services. The information on this page and the dental/medical histories are correct to the best of my knowledge. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I hereby authorize payment of insurance benefits to be made directly to the Dental Office storewise payoble to me. A copy of the dental materials fact sheet and the office's privacy policies have been made available to me. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party and/or other health professionals. I understand that if I am unable to keep this appointment I will		Y/N					
Are there any swellings, growths, inflamed areas, or unhealed injuries in or around your mouth? Does food catch between your teeth? Where: Is any part of your mouth sensitive to temperatures, biting pressure, or sweets? Y/N Have you had orthodontic treatment or bite adjustments? Y/N Do you have unreplaced missing teeth? Have you noticed any movement, shifting, or change in your teeth? Have you noticed any movement, shifting, or change in your teeth? Y/N Have you had locking or clicking in your jaw, inability to open wide or chew tough foods? Y/N Do you awaken with the awareness of your teeth and jaws? Y/N Do you dench or grind your teeth during the day or night? Y/N Do you have any pain around your eyes, ears, nose, neck, or mouth? If so, where & how often? How often do you get headaches? Do you have a history of extensive dental treatment? Has it been due to: a new cavities a gum disease replacement of dental work Do you want to keep your remaining teeth? V/N Please add anything you feel important: Name and phone number of someone not living with you to contact in case of emergency. Authorization I understand that I am responsible for all costs of dental treatment. Payment is due at the time of services. The information on this page and the dental/medical histories are correct to the best of my knowledge. I hereby authorize the bental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I hereby authorize payment of insurance benefits to be made directly to the Dental Office to therwise payoble to me. A copy of the dental materials fact sheet and the office's privacy policies have been made available to me. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party and/or other health professionals. I understand that if I am unable to keep this appointment I will give a minimum of 48 hours notice or I will be responsible for th		Y/N					
Does food catch between your teeth? Where: Is any part of your mouth sensitive to temperatures, biting pressure, or sweets? Y/N Have you had orthodontic treatment or bite adjustments? Y/N If so, why have you chosen not to replace them? Have you noticed any movement, shifting, or change in your teeth? Y/N Have you noticed any movement, shifting, or change in your teeth? Y/N Have you had locking or clicking in your jaw, inability to open wide or chew tough foods? Y/N Do you awaken with the awareness of your teeth and jaws? Y/N Do you clench or grind your teeth during the day or night? Y/N Do you have any pain around your eyes, ears, nose, neck, or mouth? Y/N If so, where & how often? How often do you get headaches? Do you have a history of extensive dental treatment? Has it been due to: new cavities gum disease replacement of dental work Do you want to keep your remaining teeth? Y/N Please add anything you feel important: Name and phone number of someone not living with you to contact in case of emergency Authorization I understand that I am responsible for all costs of dental treatment. Payment is due at the time of services. The information on this page and the dental/medical histories are correct to the best of my knowledge. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and theropeutic procedures as may be necessary for proper dental care. I hereby authorize payment of insurance benefits to be made directly to the Dental Office otherwise payable to me. A copy of the dental materials fact sheet and the office's privacy policies have been made available to me. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party and/or other health professionals. I understand that if I am unable to keep this appointment I will give a minimum of 48 hours notice or I will be responsible for the charge for time reserved.	- 뭐지하다. 그는						
Is any part of your mouth sensitive to temperatures, biting pressure, or sweets? Have you had orthodontic treatment or bite adjustments? YN Do you have unreplaced missing teeth? If so, why have you chosen not to replace them? Have you noticed any movement, shifting, or change in your teeth? Have you noticed any movement, shifting, or change in your teeth? YN Have you had locking or clicking in your jaw, inability to open wide or chew tough foods? YN Do you awaken with the awareness of your teeth and jaws? YN Do you awaken with the awareness of your teeth and jaws? YN Do you have any pain around your eyes, ears, nose, neck, or mouth? YN If so, where & how often? How often do you get headaches? Do you have a history of extensive dental treatment? Neckaches? YN Has it been due to: new cavities gum disease replacement of dental work Do you want to keep your remaining teeth? YN Please add anything you feel important: Inderstand that I am responsible for all costs of dental treatment. Payment is due at the time of services. The information on this page and the dental/medical histories are correct to the best of my knowledge. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I hereby authorize payment of insurance benefits to be made dericetly to the Dental Office of otherwise payable to me. A copy of the dental materials fact sheet and the office's privacy policies have been made available to me. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party and/or other health professionals. I understand that if I am unable to keep this appointment I will give a minimum of 48 hours notice or I will be responsible for the charge for time reserved.		Y/N					
Have you had orthodontic treatment or bite adjustments? Do you have unreplaced missing teeth? If so, why have you chosen not to replace them? Have you noticed any movement, shifting, or change in your teeth? Have you had locking or clicking in your jaw, inability to open wide or chew tough foods? Y/N Do you awaken with the awareness of your teeth and jaws? Do you clench or grind your teeth during the day or night? Do you have any pain around your eyes, ears, nose, neck, or mouth? If so, where & how often? How often do you get headaches? Do you have a history of extensive dental treatment? Has it been due to: a new cavities a gum disease replacement of dental work Do you want to keep your remaining teeth? V/N Please add anything you feel important: Inderstand that I am responsible for all costs of dental treatment. Payment is due at the time of services. The information on this page and the dental/medical histories are correct to the best of my knowledge. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I hereby authorize payment of insurance benefits to be made directly to the Dental Office otherwise payable to me. A copy of the dental materials fact sheet and the office's privacy policies have been made available to me. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third parry and/or other health professionals. I understand that if I am unable to keep this appointment I will give a minimum of 48 hours notice or I will be responsible for the charge for time reserved.		. V/N					
Do you have unreplaced missing teeth? If so, why have you chosen not to replace them? Have you noticed any movement, shifting, or change in your teeth? Y/N Have you had locking or clicking in your jaw, inability to open wide or chew tough foods? Y/N Do you awaken with the awareness of your teeth and jaws? Y/N Do you clench or grind your teeth during the day or night? No you have any pain around your eyes, ears, nose, neck, or mouth? If so, where & how often? How often do you get headaches? Do you have a history of extensive dental treatment? Neckaches? Do you have a history of extensive dental treatment? Has it been due to: new cavities new and is ease neplacement of dental work Do you want to keep your remaining teeth? Y/N Please add anything you feel important: Inderstand that I am responsible for all costs of dental treatment. Payment is due at the time of services. The information on this page and the dental/medical histories are correct to the best of my knowledge. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I hereby authorize payment of insurance benefits to be made directly to the Dental Office of therwise payable to me. A copy of the dental materials fact sheet and the office's privacy policies have been made available to me. I grant the right to the dentist to release my dental/medical histories and out the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party and/or other health professionals. I understand that if I am unable to keep this appointment I will give a minimum of 48 hours notice or I will be responsible for the charge for time reserved.							
If so, why have you chosen not to replace them? Have you noticed any movement, shifting, or change in your teeth? Y/N Have you had locking or clicking in your jaw, inability to open wide or chew tough foods? Y/N Do you awaken with the awareness of your teeth and jaws? Do you clench or grind your teeth during the day or night? Y/N Do you have any pain around your eyes, ears, nose, neck, or mouth? If so, where & how often? How often do you get headaches? Do you have a history of extensive dental treatment? Nestaches? Y/N Has it been due to: a new cavities a gum disease replacement of dental work Do you want to keep your remaining teeth? Y/N Please add anything you feel important: Name and phone number of someone not living with you to contact in case of emergency Authorization I understand that I am responsible for all costs of dental treatment. Payment is due at the time of services. The information on this page and the dental/medical histories are correct to the best of my knowledge. I hereby authorize the bental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I hereby authorize payment of insurance benefits to be made directly to the Dental Office otherwise payable to me. A copy of the dental materials fact sheet and the office's privacy policies have been made available to me. I grant the right to the dentist to release my dental/medical histories and other information bout my dental treatment to third party and/or other health professionals. I understand that if I am unable to keep this appointment I will give a minimum of 48 hours notice or I will be responsible for the charge for time reserved.		2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2					
Have you noticed any movement, shifting, or change in your teeth? Have you had locking or clicking in your jaw, inability to open wide or chew tough foods? Y/N Do you awaken with the awareness of your teeth and jaws? Do you clench or grind your teeth during the day or night? Y/N Do you have any pain around your eyes, ears, nose, neck, or mouth? How often do you get headaches? Do you have a history of extensive dental treatment? Has it been due to: new cavities gum disease replacement of dental work Do you want to keep your remaining teeth? Please add anything you feel important: Name and phone number of someone not living with you to contact in case of emergency Authorization I understand that I am responsible for all costs of dental treatment. Payment is due at the time of services. The information on this page and the dental/medical histories are correct to the best of my knowledge. I hereby outhorize the Dental Office of administer such medications and perform such diagnostic and therogenutic procedures as may be necessary for proper dental care. I hereby authorize to administer such medications and perform such diagnostic and therogenutic procedures as may be necessary for proper dental care. I hereby authorize to administer such medications and perform and/or other health professionals. I understand that if I am unable to keep this appointment I will give a minimum of 48 hours notice or I will be responsible for the charge for time reserved.	그렇게 되었다. 그는 그는 그를 가는 얼마가 내려가 그렇게 잘 되었습니다. 그를 가는 그렇게 되었다. 그는 그를 그리고 그를 그리고 그렇게 그리고 그를 그를 그리고 그를 그를 그리고 그를 그를 그리고 그를 그를 그리고 그를 그를 그리고 그를 그를 그리고 그리고 그를 그리고	7714					
Have you had locking or clicking in your jaw, inability to open wide or chew tough foods? Y/N Do you awaken with the awareness of your teeth and jaws? Do you clench or grind your teeth during the day or night? Y/N Do you have any pain around your eyes, ears, nose, neck, or mouth? Y/N If so, where & how often? How often do you get headaches? Do you have a history of extensive dental treatment? Has it been due to: new cavities gum disease replacement of dental work Do you want to keep your remaining teeth? Y/N Please add anything you feel important: Name and phone number of someone not living with you to contact in case of emergency Authorization I understand that I am responsible for all costs of dental treatment. Payment is due at the time of services. The information on this page and the dental/medical histories are correct to the best of my knowledge. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I hereby authorize payment of insurance benefits to be made directly to the Dental Office otherwise poyable to me. A copy of the dental materials fact sheet and the office's privacy policies have been made available to me. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party and/or other health professionals. I understand that if I am unable to keep this appointment I will give a minimum of 48 hours notice or I will be responsible for the charge for time reserved.		V/N					
Do you awaken with the awareness of your teeth and jaws? Do you clench or grind your teeth during the day or night? Do you have any pain around your eyes, ears, nose, neck, or mouth? If so, where & how often? How often do you get headaches? Do you have a history of extensive dental treatment? Has it been due to: new cavities gum disease replacement of dental work Do you want to keep your remaining teeth? Y/N Please add anything you feel important: Name and phone number of someone not living with you to contact in case of emergency Authorization I understand that I am responsible for all costs of dental treatment. Payment is due at the time of services. The information on this page and the dental/medical histories are correct to the best of my knowledge. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therepeutic procedures as may be necessary for proper dental care. I hereby authorize payment of insurance benefits to be made directly to the Dental Office to therwise payable to me. A copy of the dental materials fact sheet and the office's privacy policies have been made available to me. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party and/or other health professionals. I understand that if I am unable to keep this appointment I will give a minimum of 48 hours notice or I will be responsible for the charge for time reserved.	- 맛있었다면 하다. 그런 그렇게 하다면 하다면 하다면 하다면 다른데 그리는데 이번에 대한 사람들이 되었다면 하는데						
Do you clench or grind your teeth during the day or night? Do you have any pain around your eyes, ears, nose, neck, or mouth? If so, where & how often? How often do you get headaches? Do you have a history of extensive dental treatment? Has it been due to: new cavities gum disease replacement of dental work Do you want to keep your remaining teeth? Y/N Please add anything you feel important: Name and phone number of someone not living with you to contact in case of emergency Authorization I understand that I am responsible for all costs of dental treatment. Payment is due at the time of services. The information on this page and the dental/medical histories are correct to the best of my knowledge. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I hereby authorize payment of insurance benefits to be made directly to the Dental Office otherwise payable to me. A copy of the dental materials fact sheet and the office's privacy policies have been made available to me. I grant the right to the dentist to release my dental/medical histories and obout my dental treatment to third party and/or other health professionals. I understand that if I am unable to keep this appointment I will give a minimum of 48 hours notice or I will be responsible for the charge for time reserved.	그는 그						
Do you have any pain around your eyes, ears, nose, neck, or mouth? If so, where & how often? How often do you get headaches? Do you have a history of extensive dental treatment? Has it been due to: new cavities gum disease replacement of dental work Do you want to keep your remaining teeth? Y/N Please add anything you feel important: Name and phone number of someone not living with you to contact in case of emergency. Authorization I understand that I am responsible for all costs of dental treatment. Payment is due at the time of services. The information on this page and the dental/medical histories are correct to the best of my knowledge. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I hereby authorize payment of insurance benefits to be made directly to the Dental Office otherwise payable to me. A copy of the dental materials fact sheet and the office's privacy policies have been made available to me. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party and/or other health professionals. I understand that if I am unable to keep this appointment I will give a minimum of 48 hours notice or I will be responsible for the charge for time reserved.							
If so, where & how often?							
Do you have a history of extensive dental treatment? Has it been due to: new cavities gum disease replacement of dental work Do you want to keep your remaining teeth? Y/N Please add anything you feel important: Name and phone number of someone not living with you to contact in case of emergency Authorization I understand that I am responsible for all costs of dental treatment. Payment is due at the time of services. The information on this page and the dental/medical histories are correct to the best of my knowledge. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I hereby authorize payment of insurance benefits to be made directly to the Dental Office otherwise payable to me. A copy of the dental materials fact sheet and the office's privacy policies have been made available to me. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party and/or other health professionals. I understand that if I am unable to keep this appointment I will give a minimum of 48 hours notice or I will be responsible for the charge for time reserved.	If so, where & how often?						
Do you have a history of extensive dental treatment? Has it been due to: new cavities gum disease replacement of dental work Do you want to keep your remaining teeth? Y/N Please add anything you feel important: Name and phone number of someone not living with you to contact in case of emergency Authorization I understand that I am responsible for all costs of dental treatment. Payment is due at the time of services. The information on this page and the dental/medical histories are correct to the best of my knowledge. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I hereby authorize payment of insurance benefits to be made directly to the Dental Office otherwise payable to me. A copy of the dental materials fact sheet and the office's privacy policies have been made available to me. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party and/or other health professionals. I understand that if I am unable to keep this appointment I will give a minimum of 48 hours notice or I will be responsible for the charge for time reserved.							
Do you want to keep your remaining teeth? Please add anything you feel important: Name and phone number of someone not living with you to contact in case of emergency Authorization I understand that I am responsible for all costs of dental treatment. Payment is due at the time of services. The information on this page and the dental/medical histories are correct to the best of my knowledge. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I hereby authorize payment of insurance benefits to be made directly to the Dental Office otherwise payable to me. A copy of the dental materials fact sheet and the office's privacy policies have been made available to me. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party and/or other health professionals. I understand that if I am unable to keep this appointment I will give a minimum of 48 hours notice or I will be responsible for the charge for time reserved.	Do you have a history of extensive dental treatment?	Y/N					
Please add anything you feel important: Name and phone number of someone not living with you to contact in case of emergency Authorization I understand that I am responsible for all costs of dental treatment. Payment is due at the time of services. The information on this page and the dental/medical histories are correct to the best of my knowledge. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I hereby authorize payment of insurance benefits to be made directly to the Dental Office otherwise payable to me. A copy of the dental materials fact sheet and the office's privacy policies have been made available to me. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party and/or other health professionals. I understand that if I am unable to keep this appointment I will give a minimum of 48 hours notice or I will be responsible for the charge for time reserved.	Has it been due to: new cavities gum disease replacement of dental work						
Name and phone number of someone not living with you to contact in case of emergency Authorization I understand that I am responsible for all costs of dental treatment. Payment is due at the time of services. The information on this page and the dental/medical histories are correct to the best of my knowledge. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I hereby authorize payment of insurance benefits to be made directly to the Dental Office otherwise payable to me. A copy of the dental materials fact sheet and the office's privacy policies have been made available to me. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party and/or other health professionals. I understand that if I am unable to keep this appointment I will give a minimum of 48 hours notice or I will be responsible for the charge for time reserved.	Do you want to keep your remaining teeth?	Y/N					
Authorization I understand that I am responsible for all costs of dental treatment. Payment is due at the time of services. The information on this page and the dental/medical histories are correct to the best of my knowledge. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I hereby authorize payment of insurance benefits to be made directly to the Dental Office otherwise payable to me. A copy of the dental materials fact sheet and the office's privacy policies have been made available to me. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party and/or other health professionals. I understand that if I am unable to keep this appointment I will give a minimum of 48 hours notice or I will be responsible for the charge for time reserved.	Please add anything you feel important:						
Authorization I understand that I am responsible for all costs of dental treatment. Payment is due at the time of services. The information on this page and the dental/medical histories are correct to the best of my knowledge. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I hereby authorize payment of insurance benefits to be made directly to the Dental Office otherwise payable to me. A copy of the dental materials fact sheet and the office's privacy policies have been made available to me. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party and/or other health professionals. I understand that if I am unable to keep this appointment I will give a minimum of 48 hours notice or I will be responsible for the charge for time reserved.							
Authorization I understand that I am responsible for all costs of dental treatment. Payment is due at the time of services. The information on this page and the dental/medical histories are correct to the best of my knowledge. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I hereby authorize payment of insurance benefits to be made directly to the Dental Office otherwise payable to me. A copy of the dental materials fact sheet and the office's privacy policies have been made available to me. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party and/or other health professionals. I understand that if I am unable to keep this appointment I will give a minimum of 48 hours notice or I will be responsible for the charge for time reserved.	Name and phone number of someone not living with you to contact in	case of					
I understand that I am responsible for all costs of dental treatment. Payment is due at the time of services. The information on this page and the dental/medical histories are correct to the best of my knowledge. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I hereby authorize payment of insurance benefits to be made directly to the Dental Office otherwise payable to me. A copy of the dental materials fact sheet and the office's privacy policies have been made available to me. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party and/or other health professionals. I understand that if I am unable to keep this appointment I will give a minimum of 48 hours notice or I will be responsible for the charge for time reserved.	emergency	- <u>1978 1972 </u> 1					
dental/medical histories are correct to the best of my knowledge. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I hereby authorize payment of insurance benefits to be made directly to the Dental Office otherwise payable to me. A copy of the dental materials fact sheet and the office's privacy policies have been made available to me. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party and/or other health professionals. I understand that if I am unable to keep this appointment I will give a minimum of 48 hours notice or I will be responsible for the charge for time reserved.		-7_440					
Signature: X Date:	dental/medical histories are correct to the best of my knowledge. I hereby authorize the Dental Office to administer such medication such diagnostic and therapeutic procedures as may be necessary for proper dental care. I hereby authorize payment of insurance beneficiently to the Dental Office otherwise payable to me. A copy of the dental materials fact sheet and the office's privacy policies he available to me. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment and/or other health professionals. I understand that if I am unable to keep this appointment I will give a minimum of 48 hours not in the contract of	its to be made ave been made to third party					
	Signature: X Date:						