Patient Signature		Date
Time of Appointment	Reason for visit today: 🔲 Doctor	Cleaning

## Please answer all of the following questions. If you answer yes to any of the questions, please let the front desk know.

Since your last visit, has there been a:	YES	NO
1. Change in insurance?		
2. Change in address?		
3. Change in medical history?		Ū.
4. Change in medications?		

## **IMPORTANT NOTICE**

Due to the increased amount of broken or no-show appointments, we will begin charging \$25.00 for any future broken or missed appointments without the proper 24-hour notice. By signing below you acknowledge this agreement.

Patient Signature

## PATIENT INFORMATION

Date

	TREATMENT PLAN					Name		
Date	Sten	Tooth		Da	te Ste	Toot		SS/HIC/Patient ID #
8				6				Address
								- City
		ļ						
								Age Birthdate _
								Sex 🗋 Male 🛄 Fema
		+						Patient Employer/School
								- Occupation
								Employer/School Address
	-					+		_ Whom may we thank for i
								- In case of emergency who
								- in case of emergency who
								- PRIMARY INSURAN
								Person Responsible for Ac
								- Relation to Patient
							· · · · · · · · · · · · · · · · · · ·	- Address(if different from patient's)
								City
		+						Person Responsible Emplo
		1				1		- Business Address
								Insurance Company
								Contract#
			· · · · · · · · · · · · · · · · · · ·					Names of other dependents co
			A				A	
								MEDICAL HISTORY
								Physician's Name
								_ Have you ever taken any o
		<u> </u>				+		Fastin (brand names of phe
						-		<ul> <li>Have you had any serious i</li> </ul>
								Have you ever had a blood
								(Women) Are you pregnant
								— Check ( ✓ ) if you have or
		<u> </u>						Anemia
								<ul> <li>Arthritis, Rheumatism</li> <li>Artificial Heart Valves</li> </ul>
1. II 1 1 1 1 1 1 1		<u> </u>						Artificial Joints
								- Asthma
								Back Problems Blood Disease
	1					-		Cancer
		1						<ul> <li>Chemical Dependency</li> <li>Chemotherapy</li> </ul>
								Circulatory Problems
		-				-		— , — ME
								List medications
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and the state of the								
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		<u> </u>						AUTHORIZATION
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	-	1						to Dr
		1				1		understand that I am finance
								all insurance submissions.
								The above-named dentist
								Company(ies) and their ag
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iont ID #					
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INSURANCE	_				
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onsible Employe	d By		Оссир	ation	
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r dependents cover	ed under this plan				
HISTORY					
			Dat	te of Last Visit	
er taken any of th	e group of drugs co	llectively referre	d to as "fen-phen?" These i	nclude combination	ons of Ionimin, Adipe
I names of phent	ermine), Pondimin (	(fenfluramin) and	Redux (dexfenfluramine).	🗋 Yes 🔲 N	0
d any serious illo	esses or operations	? 🗋 Yes 🛛	No If yes, describe		
a any serious initi		🗋 No	If yes, give appoxima	ate dates	
-	anstusion? 🛄 Yes				
er had a blood tra	_	Nursing?	Yes 🗋 No Ta	king birth control	oills? 🗋 Yes 🗌 N
er had a blood tra e you pregnant? [	Yes No	ollowing:		-	
er had a blood tra e you pregnant? [	Yes No ve had any of the fo Cortisone Tr Cough, Pers Cough up B Diabetes	ollowing: reatments sistent		<ul> <li>Scarle</li> <li>Shortn</li> <li>Skin R</li> <li>Stroke</li> </ul>	: Fever ess of Breath ash
er had a blood tra e you pregnant? [ if you have or ha Rheumatism Heart Valves loints blems	Yes No ve had any of the fo Cortisone Tr Cough, Pers Cough up B	ollowing: reatments sistent lood	<ul> <li>Hepatitis</li> <li>High Blood Pressure</li> <li>HIV/AIDS</li> <li>Jaw Pain</li> </ul>	Scarle Shortn Skin R Stroke Swellir	Fever ess of Breath ash g of Feet or Ankles d Problems to Habit
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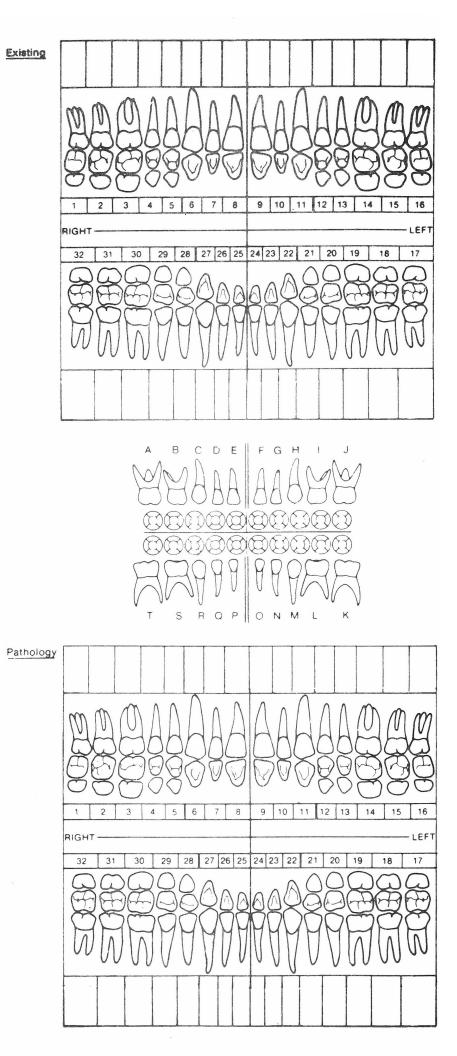
t I, and/or my dependents have insurance coverage with \_\_\_\_ \_ and assign directly Name of Insurance Company(ies) \_ all insurance benefits, if any, otherwise payable to me for services rendered. I that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on

named dentist may use my health care information and may disclose such information to the above-named Insurance es) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for rices. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative



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