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 #

W			we will be happy to help
			Patient #
			SS#/SIN
Patient Information (CONFIDENTIAL)			Date
Name Birthdate			Home Phone
Address		City	Home PhoneState/ Zip/ Prov P.C
Email			Cell Phone
Check Appropriate Box:	☐ Minor ☐ Single ☐ Married	□ Divorced □ Widowed □	☐ Separated Fig. 11.
If Student, Name of School	/College	City	State/ Full Part Prov. Time Time
Patient or Parent/Guardian	n's Employer		Work Phone
Business Address		City	State/ Zip/ Prov. P.C.
Spouse or Parent/Guardian's Name Employer			Work Phone
Whom may we thank for i	referring you?		
Person to contact in case of	of emergency		Phone
Reconcible	Party		
Responsible Party			Relationship
Name of Person Responsible for this Account			
			Cell Phone
			ution
	100 100 L		SS#/SIN
COLUMN STATE OF STATE OF	outient in our office? Yes		
			er. Payment in full at each appointment.
		VISA	wish to discuss the office's payment policy.
Insurance I	Information		
Name of Insured			Relationship to Patient
			Date Employed
Address of Employer		City	State/ Zip/ Prov. P.C.
rumess of Employer			
21101	ible? How mu	The state of the s	
DO YOU HAVE ANY A	DDITIONAL INSURANCE?	Yes No IF YES, CC	OMPLETE THE FOLLOWING:
Name of Incomed			Relationship to Patient
Name of Insured SS#/SIN			
	33#/3/11		
			State 21pi
r		Group #	
Insurance Company Ins. Co. Address		Group # City	Ctatal 7in/
How much is your deducti	ble? How much	nave you useu:	_ max. annual benefit

Over Please

Patient Medical History Office Phone Date of Last Exam ____ Physician ___ 1. Are you under medical treatment now? 10. Are you wearing contact lenses? 11. Are you allergic to or have you had any reactions to the following? 2. Have you ever been hospitalized for any Local Anesthetics (e.g. Novocain) surgical operation or serious illness within the last 5 years?..... Penicillin or any other Antibiotics If yes, please explain Sulfa Drugs Barbiturates 3. Are you taking any medication(s) including non-prescription medicine? Sedatives If yes, what medication(s) are you taking? Any Metals (e.g. nickel, mercury, etc.) 4. Have you ever taken Fen-Phen/Redux? Latex Rubber 5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? Other (please list) 12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?.... a) Are you pregnant or think you may be pregnant? 8. Do you use controlled substances? b) Are you nursing? 9. Do you have or have you had any of the following? c) Are you taking oral contraceptives?..... High Blood Pressure Heart Disease Chest Pains Heart Attack Cardiac Pacemaker Easily Winded Rheumatic Fever Heart Murmur Stroke Swollen Ankles Angina Hay Fever / Allergies Fainting / Seizures Frequently Tired Tuberculosis Ahemia Radiation Therapy Low Blood Pressure Glaucoma Emphysema Epilepsy / Convulsions Recent Weight Loss Cancer Leukemia Liver Disease Diabetes Joint Replacement or Implant Heart Trouble Kidney Diseases Hepatitis / Jaundice Respiratory Problems Sexually Transmitted Disease Mitral Valve Prolapse AIDS or HIV Infection Stomach Troubles / Ulcers Thyroid Problem Patient Dental History Date of Last Exam _____ Name of Previous Dentist and Location_ 8. Do you have frequent headaches?..... 1. Do your gums bleed while brushing or flossing?..... 2. Are your teeth sensitive to hot or cold liquids/foods?.... 9. Do you clench or grind your teeth? 3. Are your teeth sensitive to sweet or sour liquids/foods?..... 10. Do you bite your lips or cheeks frequently?..... 11. Have you ever had any difficult extractions in the past? 4. Do you feel pain to any of your teeth?.... 5. Do you have any sores or lumps in or near your mouth?..... 12. Have you ever had any prolonged bleeding 6. Have you had any head, neck or jaw injuries? following extractions? 7. Have you ever experienced any of the following 13. Have you had any orthodontic treatment?..... problems in your jaw? Clicking 14. Do you wear dentures or partials? If yes, date of placement ___ Pain (joint, ear, side of face) 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? 16. Do you like your smile? 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 answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the 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 payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits 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 for payment of all services rendered on my behalf or my dependents. Date Signature of patient (or parent/guardian if minor) Doctor's Comments __ Date Signature_

PATTERSON OFFICE SUPPLIES 1.800.637.1140 051-1014/16306