Patient Number A B C HEALTH HISTORY & REGISTRATION

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per ble and tradition				TIENT IN				garan a		La carrière			
PATIENT'S NAME Last		rst					itial SEX: M						
Soc. Sec. #	If Patie	ent is a N	/linor, gi						TODA	AY'S DATE			
Who May We Thank for Referring You to	our Office?				Reas	on for thi	is Visit		San beniseln				
		RESE	ONS	IBLE PAI	RTY INI	ORM	IATION						
NAME Last							Middle Initi	al		MARITAL STATUS			
RESIDENCE Street													
MAILING ADDRESS Street —													
HOW LONG AT THIS ADDRESS HOME PHO			ONECELL PHOI				PHONE _	NE					
WORK PHONE			E-N	//AIL									
PREVIOUS ADDRESS (if less than 3 yrs.)	Street			City			State	Zip		How Long _			
SOCIAL SECURITY #	BIR1	HDATE			DRIVER'S L	ICENSE	#	REL	ATION T	O PATIENT			
EMPLOYER		1		OCCUPATION					_ NO. \	YEARS EMPLOYED			
DECRONOLD	E DADTVIC COOL	LICE				DOEN	OV INFORMATIO	N DEL	A T1) (F	NOT LIVING	4	VO!	
NAME	LE PARTY'S SPO	USE			EME	RGEN	CY INFORMATIO	N: HEL	ATIVE	: NOT LIVING V	WITH	YOU	J.
EMPLOYER LAST	OCCUPATION	MIDDLE			NAME					RELATIONSHIP _			
SOC. SEC. #	BIRTHDATE		NC	. YEARS EMPLOYED	ADDRESS	ADDRESS				CITY, STATE			
	CELL PH.				HOME PH.				L PH				
WORK PH.	E-MAIL							ULL	L []]				
WURK PH.	_ E-IVIAIL				WORK PH				250				
DENTAL INSURANCE I	NFORMATION (Pr	rimary	Carrie	er)	If you ha	ve doub	le dental insurance o	overage,	compl	ete this for the se	cond	cover	age.
Insured's Name					Insured's	Name					- 6		
Insurance Co E-MAIL				Insurance Co.					E-MAIL				
Insurance Co. Address					Insurance	Co. Add	ress						
Insured's Employer	1 c		,		Insured's	Employe	r	1 /4					
Insured's Soc. Sec. #	Grou	ıp #	Loca	al #	Insured's	Soc. Sec	#			Group #	Local #	#	
It is important that I know	about your Madia	al and	Dontal	History The	oo footo	201/0.0	direct bearing on	vour Do	ntal L	loolth This info	rmati	on	
is strictly confidentia												011	
*DENTAL HIS		YES	NO			,	*MEDICAL HISTO	RY*			YES	N	10
HOW LONG SINCE you have seen a den Last COMPLETE Dental Exam, Date:	tist?						HEALTH PROBLEMS	?					
Last FULL MOUTH X-RAYS, DATE:(16 Small Films or Panoramic)		Are yo			ier a PHYS	S CARE now?	E HOW?						
Are you having PROBLEMS now? WHAT?				What MEDI	CATIONS	are you	currently taking?						
Is your present dental health POOR?				Have you e	ver taken F	en-Pher	n/Redux?						
Do you wear DENTURES? (Partials or Full)				Are you PR	EGNANT?								
Are you UNHAPPY with your dentures? Would you like to know more about		Ш		The second secon			pipe or chewing toba			PRESENTLY HAVE			
PERMANENT REPLACEMENTS? Are you APPREHENSIVE about dental tro	eatment?												
Have you had any PERIODONTAL (GUM				AlDS/HIV Pos. Anaphylaxis			Fainting Food allergies	001	000	Psychiatric care Rapid weight gain/loss			
Do your gums BLEED, or feel TENDER of Are your teeth SENSITIVE to hot, cold, so				Anemia Arthritis (Rheuma			Glaucoma Headaches			Radiation treatment Respiratory disease			
Are you UNHAPPY with the APPEARANCE				Artificial heart v			Heart murmur Heart problems (please de	scribe)		Rheumatic/scarlet fever Shingles			
Are you aware of GRINDING or CLENCH	,			Asthma Atopic (Allergy Pr	one)		Hemophilia (Abnormal bleed			Shortness of breath Skin rash			
Do you have HEADACHES, EARACHES, Have you worn BRACES on your teeth (C				Back problems Blood disease			Herpes Hepatitis			Spina Bifida Stroke		000	
Do you have DISCOLORED teeth that bo	ther you?			Cancer Chemical deper	idency C		High blood pressure Jaw pain			Surgical implant Swelling of feet or ankle	S	000	
Would you like your smile to LOOK BETT Do you REGULARLY use DENTAL FLOS				Chemotherapy Circulatory prof	olems E		Kidney disease or malfun Liver disease			Thyroid disease or malfu Tobacco habit	nction		
Name of Previous Dentist:				Cortisone treatr Cough (persistent)			Material allergies (latex, wool, metal, chemicals)			Tonsillitis Tuberculosis			000000000000000000000000000000000000000
City:	State:			Cough up blood Diabetes			Mitral valve prolapse Nervous problems			Ulcer/Colitis Venereal disease			
How do you feel about your teeth?				Epilepsy	EDGIC TO OR		Pacemaker/heart surgery		THE E	NI LOWING MEDICATION	ONES		
Please RANK the following in th KEEP YOU FROM havi				Aspirin Nitrous Oxide	Li	cal Anesth deine	U REACTED ADVERSELY hetic Erythro Penicill any other medications	mycin n		Latex (balloons, gloves, etc.)	MS!		
FEAR of pain	# LACK o	f concern	#	If yes, please									
				Is there any	other Medica	I or Dent	tal information that you	feel I sho	ould kno	ow about?			

FAMILY PHYSICIAN -

MISSING work time #

COST of treatment

E-MAIL

PHONE_

COMPLETED TREATMENT

OOMI LETE											
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	UTIAL DEDICOONT	TAL EVARA.			1200	INITIAL	V DAV FINDI	MCC.			
	IITIAL PERIODONT		Causes	V DAV	S TAKEN:		X-RAY FINDI		OTHER_		
GINGIVAL INFLAMMATION:	☐ Slight	☐ Moderate ☐ Moderate	☐ Severe ☐ Heavy	V-UAT	S IANEIN.	LI FIVI-FAS	I DVVA				
SOFT PLAQUE BUILDUP: HARD CALCULUS BUILDUP:	☐ Slight ☐ Light	☐ Moderate	☐ Heavy	☐ NO BONE LOSS UR UL LR						LL	
		☐ Moderate	☐ Heavy	□ SLIGHT BONE LOSS (04600)							
STAINS:	Light		☐ Poor			E LOSS (04700)					
HOME CARE EFFECTIVENESS		☐ Fair			JOR BONE LO						
PERIODONTAL CONDITION:	Good	☐ Fair	□ Poor			CATION (04700)					
PERIODONTAL DIAGNOSIS:	□ Normal	☐ Gingivitis		ACT							
PERIODONTITIS: MUCOGINGIVAL DEFECTS #s	☐ Early	☐ Moderate	☐ Advanced			CATION (04800)					
WOODANGIVIL DELEGIO "O		TA.			SH	ADE		DEDIODONITAL	CODEENING	0.0	
CLINICAL DATA: OCCLUSION: Class Class Class Crossbite:				Teeth	Upper	PERIODONTAL SCREENING & RECORDING					
OCCLUSION: ☐ Class I T.M.J. EXAM: ☐ Normal		eviation		Cents				- 112001	IDIIVG		
	INITIAL SOFT TISS	SIIF FXAM:	Baselous de la passiva de la casa de passiva de la casa	Cusp							
☐ Lips ☐ Floor of Mo	outh 🗆 Palate		☐ Neck & Nodes	1 0313		EVICTII	SEXTANT SC		DAY	YEAR	
					EXISTING PROSTHESIS: MAX: DATE PLACED: CONDITION:						
PATIENT'S TREATMENT DECISIONS: DOCUMENTATION OF DENTAL RECORD COMPLETED				MANE):	DATE PLAC		CONDIT			
PATIENT INFORMED OF TO			O TX. (ALTERNA-			R	EFERRALS:				
☐ PATIENT WANTS NO TX. OR PARTIAL TX. INFORMED OF CONSEQUENCES AND RISKS				PERIO:ORTHO:				ENDO: _	_ENDO:		
INVOLVED.				ORAL	SURG:	MD:		OTHER:			
			NO	TES							
Administration of the second											
sheet :											
43,60.2											

CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been