ADVANCED ORTHODONTIC CENTER Sam Veshkini D.M.D.

Thank You for choosing our office for you Orthodontic needs.

Whom may we thank for referring you to our office? **Patient Information** Patient's Name:

Last First Middle _____E-Mail: ____ Zip City State Social Security #: _____ Driver's License #: _____ Sex:___ Birthdate: ____ / ____ Emergency Contact: Phone: () **Responsible Party Information** Name: Middle Mailing Address: _____E-Mail: _____ How long at this address: Home Phone: () Work: () Previous Address (if less than 3 years): Street City Social Security # _____ Birthdate: ____ / ___ Relationship to patient: _____ Occupation: _____#of Years Employed: _____ Employer: Spouse's Name: ______ Relationship to Patient _____ Spouse's Employer: ______ #of Years Employed: _____ Employer's Address: Spouse's Social Security # _____ Birthdate: ___/ ___ Work Phone: (____) **Insurance Information** Subscriber's Name: _____ DOB: ___ Subscriber's Social Security # _____ Insurance Company: Insurance Company Address: Do you have dual coverage? Yes No If yes: please complete the following secondary Insurance Information. Subscriber's Name: DOB: Subscriber's Social Security # - -Insurance Company: Insurance Company Address: Phone #: (Subscriber's Employer:

What is the date of your last dental examination? Do you grand so bleed when you breash? Do you grand or detech your teach? From the proof of the	Dental Information						
Do you gums bleed when you brush? Never Non- Test Yes No Do you gum of celench your teeth? How do you feel about the appearance of your teeth? How do you feel about the appearance of your teeth? If could change my smile I would make my teeth. () Whiter () Straighter () Close Spaces () Repair Chips WHY ARE YOU HERE TODAY? Medical Information I. Are you having pain or discomfort at this time? Phone # () Have you been a patient in the hospital during the past two years? Have you been a patient in the hospital during the past two years? Here you having pain or discomfort at this time? Phone # () Address: A Please list any medication or drugs taken during the past two years? A Please list any medication or drugs taken during the past two years? A rey ou now taking any medication or drugs? YES NO Byte, please list: A rey ou sonsitive or allergic to any medication or anesthetics? A rey ou sonsitive or allergic to any medication or anesthetics? A rey ou sonsitive or allergic to any medication or anesthetics? A rey ou sonsitive or allergic to any medication or anesthetics? A rey ou sonsitive or allergic to any medication or anesthetics? A rey ou sonsitive or allergic to any medication or anesthetics? A rey ou sonsitive or allergic to any medication or anesthetics? A rey ou sonsitive or allergic to any medication or anesthetics? A rey ou sonsitive or allergic to any medication or anesthetics? A rey ou sonsitive or allergic to any medication or anesthetics? A rey ou sonsitive or allergic to any medication or anesthetics? A rey ou sonsitive or allergic to any medication or anesthetics? A rey ou sonsitive or allergic to any medication or anesthetics? A rey ou allergic to any medication or anesthetics? A rey ou allergic to any medication or anesthetics? A rey on any on all rey on any	What is the date of your last dental examination?What was done at the time?						
Do you grind or clench your teeth? Yes No	Dentist's Name City: Phone:						
How do you feel about the appearance of your teeth	Do your gums bleed when you brush?]	Never Sometin	mes	Often Always		
### WHY ARE YOU HERE TODAY? Medical Information	Do you grind or clench your teeth?		Yes No	<u>—</u>			
Medical Information	How do you feel about the appearance o	of your teeth	?				
1. Are you having pain or discomfort at this time? 2. Have you been a patient in the hospital during the past two years? 3. Have you been a patient in the hospital during the past two years? 4. Please list any medication or drugs taken during the past two years? 4. Please list any medication or drugs taken during the past two years? 5. Are you now taking any medication or drugs? 6. Are you sensitive or allergic to any medication or anesthetics? 7. Prise please list: 8. Are you now taking any medication or drugs? 9. Prise please list: 9. Are you now taking any medication or drugs? 9. Prise please list: 9. Are you now taking any medication or anesthetics? 9. Prise please list: 9. Are you now taking any medication or anesthetics? 9. Prise please list: 9. Are you now taking any medication or anesthetics? 9. Prise please list: 9. Are you now taking any medication or anesthetics? 9. Prise please list: 9. Are you now taking any medication or anesthetics? 9. Prise please list: 9. Are you now taking any medication or drugs? 9. Prise please list: 9. Are you now taking any medication or drugs? 9. Prise please list: 9. Are you was always any medication or anesthetics? 9. Prise please list: 9. Are you was always and you have had or have at present (circle "yes" or "noo" to each item): 1. Heart Murmur. 9. Prise please list: 9. Are you of a length of the following you have had or have at present (circle "yes" or "noo" to each item): 1. Heart Murmur. 9. Prise please list: 9. NO Code Sorre/Fever Bilsters Prise NO Ulcers. 9. Prise NO Code Sorre/Fever Bilsters Prise NO Ulcers. 9. Prise NO Allergy to Lacex. 9. Prise NO Allergy to Prise No. 9. Artificial ploints [Hip, knee, erc.) Prise NO Allergy to Prise No. 9. Prise NO Allerg					ose Spaces () Repa	ir Chips	
1. Are you having pain or discomfort at this time? YES NO 2. Have you been a patient in the hospital during the past two years? YES NO Physician's Name: Address: Phone # () Are you now taking any medication or drugs? YES NO Physician's Name: Address: Are you sensitive or allergic to any medication or anesthetics? YES NO Physic please list: Are you sensitive or allergic to any medication or anesthetics? YES NO Ulcers. YES NO Hard Murmur. YES NO Stroke. YES NO Ulcers. YES NO Ratical Walve Prolapse. YES NO Stroke. YES NO Ulcers. YES NO Ratical Walve Prolapse. YES NO Chemotherapy. YES NO Allergy to Latex. YES NO Rehumatic Pever. YES NO Chemotherapy. YES NO Allergy to Latex. YES NO Hard Disease or attack. YES NO Diabetes. YES NO Allergy to Latex. YES NO Hard Disease or attack. YES NO Allergy to Latex. YES NO Adjunction Therapy. YES NO Ulcers. YES NO Adjunction Therapy. YES NO Hard Disease. YES NO Adjunction Therapy. YES NO Hard Therapy. YES	WHY ARE YOU HERE TODAY?						
2. Have you been apatient in the hospital during the past two years?	Medical Information						
3. Have you been under the care of a medical doctor during the past two years? Physician's Name: Address: 4. Please list any medication or drugs taken during the past two years. 5. Are you now taking any medication or drugs. 7. Are you now taking any medication or anesthetics? 7. Are you now taking any medication or anesthetics? 7. Are you now taking any medication or anesthetics? 7. Are you now taking any medication or anesthetics? 7. Are you now taking any medication or anesthetics? 7. YES NO 8. Are you now taking any medication or anesthetics? 7. YES NO 8. Are you now taking any medication or anesthetics? 7. YES NO 8. Are you now taking any medication or anesthetics? 7. YES NO 8. Are you now taking any medication or anesthetics? 7. YES NO 8. Are you now taking any medication or anesthetics? 7. YES NO 8. Are you now taking any medication or anesthetics? 7. YES NO 8. Are you now taking any medication or anesthetics? 7. YES NO 8. Are you now taking any medication or anesthetics? 8. Are you now taking any medication or anesthetics? 8. Are you now taking any medication or anesthetics? 8. YES NO 8. Are you one specified the properties of the properties of the year of the properties of the year of year of the year of year	1. Are you having pain or discomfort a	at this time?				YES NO	
Physican's Name: Address: 4. Please list any medication or drugs taken during the past two years: 5. Are you now taking any medication or drugs? 6. Are you sensitive or allergic to any medication or anesthetics? 7. Indicate which of the following you have had or have at present (circle "yes" or "no" to each item): Heart Murmur. YES NO Stroke. YES NO Ulcers. YES NO Whital Valve Prolapse. YES NO Cancer. YES NO Cancer. YES NO Codd Sores/Fever Blisters. YES NO Rheumatic Fever. YES NO Cancer. YES NO Allergy to Lattex. YES NO High Blood Pressure. YES NO Radiation Therapy YES NO Allergy to Lattex. YES NO Algina Pectoris. Arificial Joints (Hip, knee, etc.) YES NO Ashma. YES NO Hepatitis & Girection. YES NO Ashma. YES NO Hepatitis & Girection. YES NO Allergies or Hives. YES NO Hepatitis & Girection. YES NO Allergies or Hives. YES NO Hepatitis & Girection. YES NO Heart Disease. YES NO Heart Disease. YES NO Concord. YES NO Emphysema. YES NO HIV. Positive. YES NO Heart Failure. YES NO Emphysema. YES NO Bleeding Problems. YES NO Congenital Heart Disease. YES NO Thronic Cough. YES NO Bleeding Problems. YES NO Congenital Heart Disease. YES NO Thronic Presculosis. YES NO Bleeding Problems. YES NO Congenital Heart Disease. YES NO Thronic Presculosis. YES NO Bleeding Problems. YES NO Congenital Heart Disease. YES NO Heart Superness. YES NO Glaucoma. YES NO Bredgiesy or Sciences. YES NO Bredgiesy or Scien	2. Have you been a patient in the hosp	ital during t	he past two years?			YES NO	
Address: 4. Please list any medication or drugs taken during the past two years: 5. Are you now taking any medication or drugs? 5. Are you now taking any medication or drugs? 6. Are you sensitive or allergic to any medication or anesthetics? 7. Indicate which of the following you have had or have at present (circle "yes" or "no" to each item): 1. Heart Murmur. 7. It'S NO Stroke. 7. Indicate which of the following you have had or have at present (circle "yes" or "no" to each item): 1. Heart Murmur. 7. It'S NO Stroke. 7. Indicate which of the following you have had or have at present (circle "yes" or "no" to each item): 1. Heart Murmur. 7. It'S NO Cancer. 7. YES NO Clementerapy. 7. YES NO Clementerapy. 7. YES NO Clementerapy. 7. YES NO Clementerapy. 7. YES NO Allergy to Latex. 7. YES NO High Blood Pressure. 7. YES NO Diabetes. 7. YES NO Anging Dectoris. 7. YES NO Babetes. 7. YES NO Liver Disease. 7. YES NO Heart Disease or attack. 7. YES NO Hay Fever. 7. YES NO Hepatitis A (infections). 7. YES NO Hay Fever. 7. YES NO Hepatitis A (infections). 7. YES NO Heart Palenter Valve. 7. YES NO Allergies or Hives. 7. YES NO Hepatitis B (Serum). 7. YES NO Heart Palenter Valve. 7. YES NO Sinus Trouble. 7. YES NO Heart Palenter Valve. 7. YES NO Chronic Cough. 7. YES NO House YES NO House YES NO ALD.S. 7. YES NO Heart Palenter. 7. YES NO Thereulosis. 7. YES NO Blood Transtusion. 7. YES NO Arteriosclerosis. 7. YES NO Fainting or Dizzy Spells. 7. YES NO Sickle Cell Disease. 7. YES NO Congenital Heart Disease. 7. YES NO Thyroid Problems. 7. YES NO Sickle Cell Disease. 7. YES NO Drug Addiction. 7. YES NO Thyroid Problems. 7. YES NO Developmentally Disabled YES NO Drug Addiction. 7. YES NO Thyroid Problems. 7. YES NO Drug Addiction. 7. YES NO Thyroid Problems. 7. YES NO Drug Addiction. 7. YES NO Thyroid Problems. 7. YES NO Drug Addiction. 7. YES NO Thyroid Problems. 7. YES NO No Drug Average Are you not a special dieft. 7. YES NO Thyroid Problems. 7. YES NO Drug Average Are y	3. Have you been under the care of a n	nedical docto	or during the past two ye	ears?		YES NO	
4. Please list any medication or drugs the past two years: YES NO 1/yes, please list: YES NO Yes, please list: YES NO Argina Pectoria YES NO Ashtma YES NO Heart Disease YES NO YES NO Artificial Joints (Hip, knee, etc.) YES NO Allerges or Hives YES NO Heart Disease YES NO YES NO Artificial Heart Valve YES NO Allerges or Hives YES NO YES NO Heart Surgery YES NO YES NO YES NO YES NO Heart Surgery YES NO Emphysema YES NO Bleeding Problems YES NO Artificial Heart Disease YES NO Tuberculosis YES NO Bleeding Problems YES NO Artificial Heart Disease YES NO Tuberculosis YES NO Bleeding Problems YES NO Artificial Heart Disease YES NO Tuberculosis YES NO Bleeding Problems YES NO Artificial Heart Disease YES NO Tuberculosis YES NO Bleeding Problems YES NO Artificial Heart Disease YES NO Tuberculosis YES NO Bleeding Problems YES NO Artificial Heart Disease YES NO Artificial Heart Disease YES NO Tuberculosis YES NO Bleeding Problems YES NO Artificial Heart Disease YES NO Artificial Heart Diseas	Physician's Name:			Phone #: ()		
5. Are you now taking any medication or drugs?	Address:						
Byses, please list: YES NO Are you sensitive or allergic to any medication or anesthetics? YES NO No. No. YES NO	4. Please list any medication or drugs to	aken during	the past two years:				
6. Are you sensitive or allergic to any medication or anesthetics? 7. Indicate which of the following you have had or have a present (circle "yes" or "no" to each item): Heart Murmur YES NO Stroke YES NO Ucers YES NO Hepatitis A (infections) YES NO Ucers Artificial Joints (Hip, knee, etc.) YES NO Hay Fever YES NO Hepatitis B (Serum) YES NO Ucers YES NO Hepatitis B (Serum) YES NO Ucers YES NO	5. Are you now taking any medication	or drugs?				YES NO	
7. Indicate which of the following you have had or have at present (circle "yes" or "no" to each item): Heart Murmur	If yes, please list:						
Heart Murmur YES NO Stroke YES NO Ulcers YES NO Rhitral Valve Prolapse. YES NO Cancer YES NO Condessors/Fever Blisters YES NO Rheumatic Fever. YES NO Chemotherapy YES NO Allergy to Latex YES NO High Blood Pressure. YES NO Radiation Therapy YES NO Tumors YES NO Heart Disease or attack YES NO Broadcast on Therapy YES NO Tumors YES NO Angina Pectoris YES NO Angina Pectoris YES NO Asthma YES NO Hepatitis A (infections) YES NO Angina Pectoris YES NO Asthma YES NO Hepatitis B (serum). YES NO Artificial Joints (Hip, knee, etc.) YES NO Hay Fever YES NO Hepatitis B (serum). YES NO Artificial Heart Valve YES NO Allergies or Hives YES NO Hepatitis B (serum). YES NO Heart Pacemaker YES NO Sinus Trouble YES NO Heart Pacemaker YES NO Heart Pacemaker YES NO Chronic Cough YES NO H.L.V. Positive YES NO Heart Pailure YES NO Chronic Cough YES NO H.L.V. Positive YES NO Arteriosclerosis YES NO Tuberculosis YES NO Bloed Transfusion YES NO Arteriosclerosis YES NO Fainting or Dizzy Spells YES NO Anemia YES NO Arthitis YES NO Fainting or Dizzy Spells YES NO Anemia YES NO Arthitis YES NO Fainting or Dizzy Spells YES NO Anemia YES NO Arthitis YES NO Follaucoma YES NO Sickle Cell Disease YES NO Thyroid Problems YES NO Drug Addiction YES NO Glaucoma YES NO Drug Addiction YES NO Glaucoma YES NO Drug Addiction YES NO Kidney Trouble YES NO Drug Are you have, or have you had; huy disease, condition, or problem not listed? YES NO Are you nursing? Yes No FOR WOMEN ONLY: Are you pregnant? Yes What Month? No Are you nursing? Yes No For work of the patient Signature December of the make a thorough diagnosis of the patient's dental needs. 1 Inderstand that all responsibility for payment for dental services provided in this office for my self, or my dependents, is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon addiction to any collection charges. 1 I Lunderstand that where appropriate, credit burear reports may be obtained. 2 I also authori						YES NO	
Mitral Valve Prolapse					· ·		
Rheumatic Fever							
High Blood Pressare. YES NO Radiation Therapy YES NO Tumors YES NO Heart Disease or attack YES NO Diabetes YES NO Liver Disease YES NO Angina Pectoris YES NO Asthma YES NO Hepatitis A (infections) YES NO Artificial Joints (Hip, knee, etc.) YES NO Hay Fever YES NO Hepatitis B (Serum). YES NO Artificial Heart Valve YES NO Hay Fever YES NO Hepatitis B (Serum). YES NO Artificial Heart Valve YES NO Heart Feveral Disease YES NO Heart Pacemaker YES NO Sinus Trouble YES NO Heart Positive YES NO Heart Pacemaker YES NO Sinus Trouble YES NO A.I.D.S. YES NO Heart Pacemaker YES NO Chronic Cough YES NO H.I.V. Positive YES NO Heart Failure YES NO Emphysema YES NO Blood Transfusion YES NO Heart Failure YES NO Emphysema YES NO Bleeding Problems YES NO Congenital Heart Disease YES NO Tuberculosis YES NO Bleeding Problems YES NO Congenital Heart Disease YES NO Fainting or Dizay Spells YES NO Anemia YES NO Arthritis YES NO Fainting or Dizay Spells YES NO Anemia YES NO Arthritis YES NO Thyroid Problems YES NO Bruise Easily YES NO Cortisone Medication YES NO Thyroid Problems YES NO Bruise Easily YES NO Cortisone Medication YES NO Glaucoma YES NO Nervousness YES NO Proug Addiction YES NO Kidney Trouble YES NO Nervousness YES NO Nervousness YES NO Nervousness YES NO TOR WOMEN ONLY: Are you pregnant? Yes What Month? YES NO Mervousness YES NO Are you naw or have you had any disease, condition, or problem, not listed? A YES NO Are you nursing? Yes No For Women Only: Yes No Momen of the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. Patient Signature Date 1. The understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. Patient Signature Date Wes NO Are you nursing? Yes No Are you nursing? Yes No Are you nursing? Yes No Are you and the doctor in order to make a thorough diagnosis of the patient'	*						
Heart Disease or attack YES NO Diabetes YES NO Liver Disease YES NO Angina Pectoris YES NO Angina Pectoris YES NO Ashma YES NO Hepatitis A (infections) YES NO Artificial Joints (Hip, knee, etc.) YES NO Hay Fever YES NO Hepatitis B (kerum). YES NO Artificial Heart Valve YES NO Allergies or Hives YES NO Venereal Disease YES NO Heart Pacemaker YES NO Allergies or Hives YES NO Venereal Disease YES NO Heart Pacemaker YES NO Chronic Cough YES NO A.I.D.S. YES NO Heart Pacemaker YES NO Chronic Cough YES NO H.I.D. Positive YES NO Heart Failure YES NO Emphysema YES NO Blood Transfusion YES NO Arteriosclerosis YES NO Fainting or Dizzy Spells YES NO Blood Transfusion YES NO Arthritis YES NO Fainting or Dizzy Spells YES NO Acmini YES NO Arthritis YES NO Epilepsy or Seizures YES NO Sickle Cell Disease YES NO Remains YES NO Epilepsy or Seizures YES NO Bruise Easily YES NO Arthritis YES NO Glaucoma YES NO Glaucoma YES NO Bruise Easily YES NO Drug Addiction YES NO Glaucoma YES NO Nervousness YES NO Nerv							
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Artificial Joints (Hip, knee, etc.) YES NO Hay Fever YES NO Hepatitis B (Serum). YES NO Artificial Heart Valve. YES NO Allergies or Hives. YES NO Venereal Disease. YES NO Heart Pacemaker. YES NO Sinus Trouble. YES NO A.I.D.S. YES NO Heart Pacemaker. YES NO Sinus Trouble. YES NO A.I.D.S. YES NO Heart Pacemaker. YES NO Chronic Cough. YES NO H.I.V. Positive. YES NO Heart Failure. YES NO Emphysema. YES NO Blood Transfusion. YES NO Arteriosclerosis. YES NO Emphysema. YES NO Blood Transfusion. YES NO Congenital Heart Disease. YES NO Tuberculosis. YES NO Blood Transfusion. YES NO Congenital Heart Disease. YES NO Fainting or Dizzy Spells. YES NO Anemia. YES NO Arthritis. YES NO Epilepsy or Scizures. YES NO Sickle Cell Disease. YES NO Arthritis. YES NO Thyroid Problems. YES NO Sickle Cell Disease. YES NO Cortisone Medication. YES NO Glaucoma. YES NO Developmentally Disabled YES NO Drug Addiction. YES NO Glaucoma. YES NO Developmentally Disabled YES NO Drug Addiction. YES NO Kidney Trouble. YES NO Nervousness. YES NO FOR WOMEN ONLY: Are you pregnant? Yes What Month? YES NO Are you taking birth control pills? Yes NO Thyroid Problem not listed? And YES NO FOR WOMEN ONLY: Are you pregnant? Yes What Month? No Are you taking birth control pills? Yes NO Developmentally pisabled YES NO FOR WOMEN ONLY: Are you pregnant? Yes What Month? No Are you taking birth control pills? Yes NO Developmentally pisabled YES NO FOR WOMEN ONLY: Are you pregnant? Yes What Month? No Are you taking birth control pills? Yes No Developmentally pisabled YES NO FOR WOMEN ONLY: Are you pregnant? Yes What Month? No Are you taking birth control pills? Yes No Developmentally pisabled YES NO FOR WOMEN ONLY: Are you pregnant? Yes What Month? No Are you taking birth control pills? Yes No Are you take appropriate by the doctor to perform all recommended treatment mutually agreed upon by me and the doctor, and to use the appropriate by the doctor to order to make a thorough diagnosis of the patient's dental needs. 2. I also authorize the doctor to perform all							
Artificial Heart Valve YES NO Allergies or Hives YES NO Venereal Disease YES NO Heart Pacemaker YES NO Sinus Trouble YES NO ALDS. YES NO Heart Parlemaker YES NO Sinus Trouble YES NO ALDS. YES NO Heart Surgery YES NO Chronic Cough YES NO H.I.V. Positive YES NO Heart Failure YES NO Emphysema YES NO Blood Transfusion YES NO Atteriosclerosis YES NO Tuberculosis YES NO Blood Transfusion YES NO Arteriosclerosis YES NO Tuberculosis YES NO Blood Transfusion YES NO Arteriosclerosis YES NO Tuberculosis YES NO Blood Transfusion YES NO Arteriosclerosis YES NO Fainting or Dizzy Spells YES NO Bleeding Problems YES NO Arthritis YES NO Epilepsy or Seizures YES NO Sickle Cell Disease YES NO Rheumatism YES NO Epilepsy or Seizures YES NO Bruise Easily YES NO Rheumatism YES NO Thyroid Problems YES NO Bruise Easily YES NO Cortisone Medication YES NO Glaucoma YES NO Developmentally Disabled YES NO Drug Addiction YES NO Kidney Trouble YES NO Nervousness YES NO Servousness YES NO No pour have, or have you had, any disease, condition, or problem not listed? YES NO Nervousness YES NO Are you taking birth control pills? Yes NO No Are you taking birth control pills? Yes NO No Are you taking birth control pills? Yes NO No Are you taking birth control pills? Yes NO No Are you taking birth control pills? Yes NO No Are you taking birth control pills? Yes NO No Are you taking birth control pills? Yes NO No No Are you nursing? Yes No No Are you taking birth control pills? Yes NO No No Are you nursing? Yes No No Are you taking birth control pills? Yes NO No No Are you nursing? Yes No No No Are you preparate by the doctor in order to make a thorough diagnosis of the patient's dental needs. 1 I understand that all responsibility for payment for dental services provided in this office for my self, or my dependents, is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my	~						
Heart Pacemaker YES NO Sinus Trouble YES NO A.I.D.S. YES NO Heart Surgery YES NO Chronic Cough YES NO H.I.V. Positive YES NO Heart Failure YES NO Emphysema YES NO Blood Transfusion YES NO Arteriosclerosis YES NO Tuberculosis YES NO Blood Transfusion YES NO Arteriosclerosis YES NO Tuberculosis YES NO Bleeding Problems YES NO Congenital Heart Disease YES NO Fainting or Dizzy Spells YES NO Anemia YES NO Arthritis YES NO Epilepsy or Seizures YES NO Sickle Cell Disease YES NO Arthritis YES NO Epilepsy or Seizures YES NO Bruise Easily YES NO Cortisone Medication YES NO Glaucoma YES NO Developmentally Disabled YES NO Drug Addiction YES NO Glaucoma YES NO Developmentally Disabled YES NO Drug Addiction YES NO Kidney Trouble YES NO Nervousness YES NO So you have, or have you had any disease, condition, or problem not listed? YES NO Nervousness YES NO FOR WOMEN ONLY: Are you pregnant? Yes What Month? No Are you nursing? Yes NO Are you taking birth control pills? Yes NO No Are you taking birth control pills? Yes NO No Are you have, or have you had any disease, condition, or problem not listed? No Are you nursing? Yes No Are you taking birth control pills? Yes NO No Are you taking birth control pills? Yes NO No Are you have, or have you had any disease, to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. Patient Signature Date 1. The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or other diagnostic aids deemed appropriate by the doctor in order to make a thorough diagnosis of the patient's dental needs. 2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and the doctor, and to use the appropriate medication and therapy indicated for such treatment. 3. I understand that all responsibility for payment for dental services provided in this office for myself, or my dependents, is mine, due and payable at the time services are rendered unless other arrangements h							
Heart Surgery YES NO Chronic Cough YES NO H.L.V. Positive YES NO Heart Failure YES NO Emphysema YES NO Bloed Transfusion YES NO Arteriosclerosis YES NO Tuberculosis YES NO Bleeding Problems YES NO Congenital Heart Disease YES NO Fainting or Dizzy Spells YES NO Anemia YES NO Arthritis YES NO Fainting or Dizzy Spells YES NO Anemia YES NO Arthritis YES NO Fpilepsy or Seizures YES NO Sickle Cell Disease YES NO Reumatism YES NO Thyroid Problems YES NO Bruise Easily YES NO Cortisone Medication YES NO Thyroid Problems YES NO Developmentally Disabled YES NO Drug Addiction YES NO Kidney Trouble YES NO Nervousness YES NO Are you on a special diet? YES NO Kidney Trouble YES NO Nervousness YES NO Problems YES NO Problems YES NO Nervousness YES NO Problems Only Are you have, or have you had, any disease, condition, or problem not listed? YES NO Are you nursing? Yes NO Are you taking birth control pills? Yes NO No Are you taking birth control pills? Yes NO No Are you have, or have you have, or how to the doctor to take x-rays, study models, photographs, or other diagnostic aids deemed appropriate by the doctor in order to make a thorough diagnosis of the patient's dental needs. 1 Inderstand that all responsibility for payment for dental services provided in this office for myself, or my dependents, is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges. 1 I understand that all responsibility for payment for dental services provided in this office for myself, or my dependents, is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges. 1 Inderstand that it is my responsibility							
Heart Failure							
Arteriosclerosis YES NO Tuberculosis YES NO Bleeding Problems YES NO Congenital Heart Disease YES NO Fainting or Dizzy Spells YES NO Anemia YES NO Arthritis YES NO Fainting or Dizzy Spells YES NO Anemia YES NO Arthritis YES NO Fainting or Dizzy Spells YES NO Anemia YES NO Arthritis YES NO Fainting or Dizzy Spells YES NO Anemia YES NO Anthritis YES NO Grotisone Medication YES NO Thyroid Problems YES NO Bruise Easily YES NO Cortisone Medication YES NO Glaucoma YES NO Developmentally Disabled YES NO Drug Addiction YES NO Glaucoma YES NO Developmentally Disabled YES NO Drug Addiction YES NO Kidney Trouble YES NO Nervousness YES NO Por Not	~ ·						
Congenital Heart Disease			ž •				
Arthritis							
Rheumatism							
Cortisone Medication							
Drug Addiction			•		•		
8. Are you on a special diet?							
FOR WOMEN ONLY: Are you pregnant? Yes What Month? No Are you nursing? Yes No Are you taking birth control pills? Yes NO	8 Are you on a special dief		Ridiley Houble	. 1123 140			
FOR WOMEN ONLY: Are you pregnant? Yes What Month? No Are you nursing? Yes No Are you taking birth control pills? Yes NO	9. Do you have or have you had any	disease can	lition or problem not lie	Chata	7 Y X		
Are you taking birth control pills? YesNO I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. Patient Signature	FOR WOMEN ONLY: Are you presented you. What Month?						
I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. Patient Signature Date	Are you taking hirth control pills? Yes	NO	- What Worth:		Tric you nursing.	10	
Patient Signature	The you taking birth control pins: Tes_	+"\\	_ / \	/	/		
Patient Signature	Lundoustand the share information do no		م المكاملة المناسبة	lus in also cos	Sd off signs many on These		
Patient Signature				ire in a saie ai	nd emcient manner. I nav	e answered all	
 The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or other diagnostic aids deemed appropriate by the doctor in order to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and the doctor, and to use the appropriate medication and therapy indicated for such treatment. I understand that all responsibility for payment for dental services provided in this office for myself, or my dependents, is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges. I acknowledge that I have reviewed a copy of the Dental Materials Fact Sheet and HIPPA Notice of Privacy Practices. I understand that, where appropriate, credit bureau reports may be obtained. I understand that it is my responsibility to advise your office of any changes in the information contained on this form. 	•						
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