HEALTH HISTORY & REGISTRATION

RESIDENCE Street					FORMATIO						
RESPONSIBLE PARTY/BILLING INFORMATION NAME Last First Middle Initial Merital Status RESIDENCE Street Apt # City State Zip MARLING ADDRESS Street Street Apt # City State Zip MARLING ADDRESS Street CELL PHONE WORK PHONE EMAIL MERITA BETT AND STATE CITY STATE ZIP HOW long SOCIAL SECURITY # BIRTHOATE CITY STATE COCUPATION NO. OF YEARS EMPLOYED OCCUPATION NO. OF YEARS EMPLOYED FOLICY HOLDER'S INAME PRESPONSIBLE PARTY'S SPOUSE NAME RESPONSIBLE PARTY'S SPOUSE NAME RESPONSIBLE PARTY'S SPOUSE NAME MERITA BIRTHOATE CITY STATE CELL PH. WORK PH	PATIENT'S NAME LastFirs								SEX:	M	F
RESPONSIBLE PARTY/BILLING INFORMATION NMIDD Last RESIDENCE Street Apt # City State Zip MALLING ADDRESS Street Apt # City State Zip MALLING ADDRESS Street Apt # City State Zip MALLING ADDRESS Street Apt # City State Zip MORK PHONE MORK PHONE MORK PHONE EMPLOYER COLUBRITION COLUBRITION RESPONSIBLE PARTY'S SPOUSE RESPONSIBLE PARTY'S SPOUSE RESPONSIBLE PARTY'S SPOUSE RESPONSIBLE PARTY'S SPOUSE REPROVER OCCUPATION NO. OF YEARS EMPLOYED MALLING ADDRESS (if least than 3 yrs.) Street COLUBRITION RESPONSIBLE PARTY'S SPOUSE RESPONSIBLE PARTY'S SPOUSE RESPONSIBLE PARTY'S SPOUSE REPROVER OCCUPATION NO. OF YEARS EMPLOYED MAME RELATION TO PATIENT MAME RELATION SIDE TO PATIENT MAME RELATION SIDE MAME RELATION SID	BIRTHDATE	How did you	hear ab	out our o	ffice?						
NAME Last First Middle Initial Marital Status Zip State Zip MAILING ADDRESS Street Apt # City State Zip MAILING ADDRESS Street Apt # City State Zip MAILING ADDRESS Street City State Zip MAILING ADDRESS Street City State Zip Move Move	Reason for this Visit						T0	DAY'S DATE			
NAME Last First Middle Initial Marital Status Zip State Zip MAILING ADDRESS Street Apt # City State Zip MAILING ADDRESS Street Apt # City State Zip MAILING ADDRESS Street City State Zip MAILING ADDRESS Street City State Zip Move Move		RESP	ONSIRLI	F PΔRTY /	RILLING IN	IFOR	RMATION				
RESIDENCE Street	NAME Last							Marita	l Status		
MALING ADDRESS (Ir less than 3 yrs) Street CELL PHONE CELL PHONE CITY STATE CITY STATE CELL PHONE RESPONSIBLE PARTY'S SPOUSE RESPONSIBLE PARTY'S SPOUSE RESPONSIBLE PARTY'S SPOUSE NAME RESPONSIBLE PARTY'S SPOUSE RESPONSIBLE PARTY'S SPOUSE NAME CELL PH. WORK PH. CELL PH. WORK PH. DENTAL INSURANCE INFORMATION (Primary Carrier) POLICY HOLDER'S SMPLOYER POLICY HOLDER'S SMPLOYER POLICY HOLDER'S SMPLOYER INSURANCE CO. RESPONSIBLE PARTY'S SPOUSE REMERGENCY CONTACT INFORMATION NAME RELATIONSHIP ADDRESS CITY SECONDARY INSURANCE (If applicable) POLICY HOLDER'S SMPLOYER INSURANCE CO. REMBER ID or SOCIAL SECURITY # GROUP # PHONE NO. BERMAL HISTORY YES NO BERMAL HISTORY THIS important that we know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This Information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire. BERMAL HISTORY YES NO BERMAL HISTORY YES NO DENTAL HIS											
HOME PHONE					-		•		•		
RESPONSIBLE PARTY'S SPOUSE NAME RELATION TO PATIENT RELATION TO PATIENT RESPONSIBLE PARTY'S SPOUSE NAME RELATION TO PATIENT RESPONSIBLE PARTY'S SPOUSE REMERGENCY CONTACT INFORMATION NAME RELATION TO PATIENT RELAT					-		•		•		
SOCIAL SECURITY # BIRTHDATE	EMAIL										
SOCIAL SECURITY # BIRTHDATE	PREVIOUS ADDRESS (if less than 3	vrs) Street			City		State	Zip	How long		
RESPONSIBLE PARTY'S SPOUSE NAME PMPLOYER OCCUPATION OCCUPATION SOC. SECURITY # BIRTHDATE HOME PH. CELL PH. WORK PH. EMAIL DENTAL INSURANCE INFORMATION (Primary Carrier) POLICY HOLDER'S EMPLOYER NISURANCE CO. MEMBER ID OF SOCIAL SECURITY # PHONE NO. It is important that we know about your Medical and Dental History. Those facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this estionnaire. DENTAL INSURANCE CO. MEMBER ID OF SOCIAL SECURITY # GROUP # PHONE NO. It is important that we know about your Medical and Dental History. Those facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this estionnaire. DENTAL INSTORY VES NO MEMBER ID OF SOCIAL SECURITY # GROUP # PHONE NO. BEVIAL HISTORY VES NO Date of last EPULL MOUTH XRRN's ignoral have revourneed. Are you under a PULL MOUTH XRRN's ignoral have revourneed. Are you under the PREPAIGHMENT of the VIDER'S PREPAIGH					-				_		
NAME RELATIONSHIP EMPLOYER OCCUPATION BIRTHDATE COUNTY BIRTHDATE COUNTY BIRTHDATE COUNTY BIRTHDATE COUNTY STATE COUNTY STATE COUNTY STATE COUNTY BOUNDARY INSURANCE (If applicable) POLICY HOLDER'S NAME POLICY HOLDER'S RAME POLICY HOLDER'S SEMPLOYER INSURANCE CO. MEMBER ID or SOCIAL SECURITY # GROUP # PHONE NO. It is important that we know about your Medical and Dental History. These facts have a direct bearing an your Dental Health. This information is strictly confidential and will not be released to anyone. It is important that we know about your Medical and Dental History. These facts have a direct bearing an your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire. Deter of last COMPLETE Dental Exam Are you under a PHYSICIAN'S CARE NOW? Is your present dental health POOR? Do you ware of Dental Health POOR? Is your present dental health POOR? Do you ware of DENTILLES (Partials of July) Are you ever used a Bis/PHOSPHONIATE MARKED (CAIRS) CARE NOW? Are you tent PREMINERS? (Partials of July) Are you under a PHYSICIAN'S CARE NOW? ARE you thank providentures? Are you tent's PERIODONYILL (GIMM) treatments? Are you ware of GRINDING or CLENCHING your teeth? Are you ware of GRINDING or CLENCHING your teeth? Are you ware of GRINDING or CLENCHING your teeth? PRESAMANENT REPLACEMENTS? Are you ware of GRINDING or CLENCHING your teeth? Are you worn BRACES on your teeth? Are you worn BRACES on your teeth? Are you worn BRACES on your teeth? Poo you make DEAD, or you have send or you ware of GRINDING or CLENCHING your teeth? PRESAMANENT REPLACEMENTS? ARE you worn BRACES on your teeth? Are you worn BRACES on your teeth? Are you were I shall be about dont and treatment? Are you were I shall be pour smile to LOOK BETTER or DIFFERENT? CHARLES AND A SHALL Were DENTAL GROUP or Ware And OR PRESENTLY AND A SHALL AND A SHA											
NAME RELATIONSHIP EMPLOYER OCCUPATION BIRTHDATE COUNTY BIRTHDATE COUNTY BIRTHDATE COUNTY BIRTHDATE COUNTY STATE COUNTY STATE COUNTY STATE COUNTY BOUNDARY INSURANCE (If applicable) POLICY HOLDER'S NAME POLICY HOLDER'S RAME POLICY HOLDER'S SEMPLOYER INSURANCE CO. MEMBER ID or SOCIAL SECURITY # GROUP # PHONE NO. It is important that we know about your Medical and Dental History. These facts have a direct bearing an your Dental Health. This information is strictly confidential and will not be released to anyone. It is important that we know about your Medical and Dental History. These facts have a direct bearing an your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire. Deter of last COMPLETE Dental Exam Are you under a PHYSICIAN'S CARE NOW? Is your present dental health POOR? Do you ware of Dental Health POOR? Is your present dental health POOR? Do you ware of DENTILLES (Partials of July) Are you ever used a Bis/PHOSPHONIATE MARKED (CAIRS) CARE NOW? Are you tent PREMINERS? (Partials of July) Are you under a PHYSICIAN'S CARE NOW? ARE you thank providentures? Are you tent's PERIODONYILL (GIMM) treatments? Are you ware of GRINDING or CLENCHING your teeth? Are you ware of GRINDING or CLENCHING your teeth? Are you ware of GRINDING or CLENCHING your teeth? PRESAMANENT REPLACEMENTS? Are you ware of GRINDING or CLENCHING your teeth? Are you worn BRACES on your teeth? Are you worn BRACES on your teeth? Are you worn BRACES on your teeth? Poo you make DEAD, or you have send or you ware of GRINDING or CLENCHING your teeth? PRESAMANENT REPLACEMENTS? ARE you worn BRACES on your teeth? Are you worn BRACES on your teeth? Are you were I shall be about dont and treatment? Are you were I shall be pour smile to LOOK BETTER or DIFFERENT? CHARLES AND A SHALL Were DENTAL GROUP or Ware And OR PRESENTLY AND A SHALL AND A SHA											
EMPLOYER OCCUPATION ADDRESS SOC. SECURITY # BIRTHDATE CELL PH. WORK PH. CELL PH. WORK PH. EMAIL DENTAL INSURANCE INFORMATION (Primary Carrier) POLICY HOLDER'S NAME POLICY HOLDER'S MANE POLICY HOLDE		PARTY'S SPOUSI	E					ACT INFORM	IATION		
SOC. SECURITY # BIRTHDATE OTTY STATE OTHER PH. CELL PH. WORK PH. WORK PH. CELL PH. WORK PH. WORK PH. EMAIL DENTAL INSURANCE INFORMATION (Primary Carrier) POLICY HOLDER'S NAME POLICY HOLDER'S NAME POLICY HOLDER'S EMPLOYER INSURANCE CO. MEMBER ID or SOCIAL SECURITY # GROUP # PHONE NO. MEMBER ID or SOCIAL SECURITY # GROUP # PHONE NO. MEMBER ID or SOCIAL SECURITY # GROUP # PHONE NO. MEMBER ID or SOCIAL SECURITY # GROUP # PHONE NO. MEMBER ID or SOCIAL SECURITY # GROUP # PHONE NO. MEMBER ID or SOCIAL SECURITY # GROUP # PHONE NO. MEMBER ID or SOCIAL SECURITY # GROUP # PHONE NO. MEMBER ID or SOCIAL SECURITY # GROUP # PHONE NO. MEDICAL HISTORY YES NO HOW LONG SINCE you have seen a dentist? Do you have any CURRENT HEALTH PROBLEMS? DO you have any CURRENT HEALTH PROBLEMS? Date of last COMPLETE Dental Exam Are you under a PHYSICIAN'S CARE NOW? DO you have presented dental health POOR? Is your present dental health POOR? DO you wave DENTILLEM MOUTH KARR'S assent inversor Presented. Provided History Report Security (August 2) Are you UNINAPPY with your dentures? Are you UNINAPPY with your dentures? DO you wave CICARS. CIGARETTES. CHEWING TOBACCO, or a VAPE? (circle) PREMANNENT REPLACEMENTS? Are you UNINAPPY with your dentures? DO you wave CICARS. CIGARETTES. CHEWING TOBACCO, or a VAPE? (circle) PREMANNENT REPLACEMENTS? Are you aware of GRINDING or CIENCHING your teeth? DO you wave CICARS. CIGARETTES. CHEWING TOBACCO, or a VAPE? (circle) PRINGER ON YOUR AREA (CIARCE) PRINGER ON YOUR SOCIAL SECURITY WES: NO SONTRESS OF NOOTH FOLLOWING (RES FYOU AND HE ADD OR PRESENT) WATER AND AREA (CIARCE) PRINGER ON YOUR SONTRESS OR NOOTH FOLLOWING (RES FYOU AND HEAD OR PRESENT) WATER. AND AREA (CIARCE) PRINGER ON YOUR SONTRESS OR NOOTH FOLLOWING (RES FYOU AND HEAD OR PRESENT) WATER. AND AREA (CIARCE) PRINGER ON YOUR SONTRESS OF NOOTH FOLLOWING (RES FYOU AND HEAD OR PRESENT) WATER. AND AREA (CIARCE) PRINGER ON YOUR SONTRESS OF NOOTH FOLLOWING (RES FYOU AND HEAD OR PRESENT) WATER. AND AREA (CIARCE) PRINGER ON YOUR SONTRESS		OCCUPATION						RELATIONS	SHIP		
HOME PH CELL PH DENTAL INSURANCE INFORMATION (Primary Carrier) POLICY HOLDER'S NAME POLICY HOLDER'S EMPLOYER INSURANCE CO. MEMBER ID OR SOCIAL SECURITY # GROUP # PHONE NO. INSURANCE CO. MEMBER ID OR SOCIAL SECURITY # GROUP # PHONE NO. INSURANCE CO. MEMBER ID OR SOCIAL SECURITY # GROUP # PHONE NO. INSURANCE CO. MEMBER ID OR SOCIAL SECURITY # GROUP # PHONE NO. INSURANCE CO. MEMBER ID OR SOCIAL SECURITY # GROUP # PHONE NO. INSURANCE CO. MEMBER ID OR SOCIAL SECURITY # GROUP # PHONE NO. INSURANCE CO. MEMBER ID OR SOCIAL SECURITY # GROUP # PHONE NO. INSURANCE CO. MEMBER ID OR SOCIAL SECURITY # GROUP # PHONE NO. INSURANCE CO. MEMBER ID OR SOCIAL SECURITY # GROUP # PHONE NO. INSURANCE CO. MEMBER ID OR SOCIAL SECURITY # GROUP # PHONE NO. INSURANCE CO. MEMBER ID OR SOCIAL SECURITY # GROUP # PHONE NO. INSURANCE CO. MEMBER ID OR SOCIAL SECURITY # GROUP # PHONE NO. INSURANCE CO. MEMBER ID OR SOCIAL SECURITY # GROUP # PHONE NO. INSURANCE CO. MEMBER ID OR SOCIAL SECURITY # GROUP # PHONE NO. INSURANCE CO. MEMBER ID OR SOCIAL SECURITY # GROUP # PHONE NO. INSURANCE CO. MEMBER ID OR SOCIAL SECURITY # GROUP # PHONE NO. INSURANCE CO. MEMBER ID OR SOCIAL SECURITY # GROUP # PHONE NO. INSURANCE CO. MEMBER ID OR SOCIAL SECURITY # GROUP # PHONE NO. INSURANCE CO. MEMBER ID OR SOCIAL SECURITY # GROUP # PHONE NO. INSURANCE CO. MEMBER ID OR SOCIAL SECURITY # GROUP # PHONE NO. INSURANCE CO. MEMBER ID OR SOCIAL SECURITY # GROUP # PHONE NO. INSURANCE CO. MEMBER ID OR SOCIAL SECURITY # GROUP # PHONE NO. INSURANCE CO. MEMBER ID OR SOCIAL SECURITY # GROUP # PHONE NO. INSURANCE CO. MEMBER ID OR SOCIAL SECURITY # GROUP # PHONE NO. INSURANCE CO. MEMBER ID OR SOCIAL SECURITY # GROUP # PHONE NO. INSURANCE CO. INSUR											
DENTAL INSURANCE INFORMATION (Primary Carrier) POLICY HOLDER'S NAME POLICY HOLDER'S EMPLOYER INSURANCE CO. MEMBER ID or SOCIAL SECURITY # GROUP # PHONE NO. It is important that we know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill on this questionnaire. DENTAL INSURANCE CO. MEMBER ID or SOCIAL SECURITY # GROUP # PHONE NO. It is important that we know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This Information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill on this questionnaire. DENTAL INSURANCE CO. MEMBER ID or SOCIAL SECURITY # GROUP # PHONE NO. It is important that we know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This Information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill on this questionnaire. DENTAL INSURANCE CO. MEMBER ID or SOCIAL SECURITY # GROUP # PHONE NO. IT is important that we know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This Information is strictly confidential that is questionnaire. Dental Health. This information is strictly confidential that is questionnaire. WEMBER ID or SOCIAL SECURITY # GROUP # PHONE NO. MEMBER ID or SOCIAL SECURITY # GROUP # PHONE NO. MEMBER ID or SOCIAL SECURITY # GROUP # PHONE NO. MEMBER ID or SOCIAL SECURITY # GROUP # PHONE NO. MEMBER ID or SOCIAL SECURITY # GROUP # PHONE NO. MEMBER ID or SOCIAL SECURITY # GROUP # PHONE NO. MEMBER ID or SOCIAL SECURITY # GROUP # PHONE NO. MEMBER ID or SOCIAL SECURITY # GROUP # PHONE NO. MEMBER ID or SOCIAL SECURITY # GROUP # PHONE NO. MEMBER ID or SOCIAL SECURITY # GROUP # PHONE NO. MEMBER ID or SOCIAL SECURITY # PHONE NO. MEMBER ID or SOCIAL SECURITY #											
DENTAL INSURANCE INFORMATION (Primary Carrier) POLICY HOLDER'S NAME POLICY HOLDER'S SAME POLI					CELL PH.			WORK PH.			
POLICY HOLDER'S NAME POLICY HOLDER'S EMPLOYER INSURANCE CO. MEMBER ID or SOCIAL SECURITY # GROUP # PHONE NO. It is important that we know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire. DENTAL HISTORY YES NO MEDICAL HISTORY PHONE NO. MEDICAL HISTORY MEDICAL HISTORY PENDAL HISTORY PENDAL HISTORY PENDAL HISTORY PENDAL HISTORY POUL ON HAVE SEEN AND HEALTH PROBLEMS? Date of last FULL MOUTH RAYEN is growed Previousing Proportions of Previousing Proportions o	WORK PH	EMAIL									
POLICY HOLDER'S EMPLOYER INSURANCE CO. MEMBER ID or SOCIAL SECURITY # GROUP # PHONE NO. It is important that we know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to complete printing on your Dental Health. This information is strictly confidential and will not be released to anyone. DENTAL HISTORY YES NO HOW LONG SINCE you have seen a dentist? Date of last COMPETE Dental Exam Are you under a PHYSICIAN'S CARE NOW? Date of last COMPETE Dental Exam Are you under a PHYSICIAN'S CARE NOW? What MEDICATIONS are you currently taking? What MEDICATIONS are pour currently taking? What MEDICATIONS are you currently taking the fact of the fact of the fact of the fact of the fact o	DENTAL INSURANCE INFO	RMATION (Primar	y Carrier)		POLICY HO	S DI DE	ECONDARY INSURA	ANCE (If app	licable)		
INSURANCE CO. MEMBER ID or SOCIAL SECURITY # GROUP # PHONE NO. It is important that we know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire. DENTAL HISTORY YES NO HOW LONG SINCE you have seen a dentist? Date of last GOMPLETE Dental Exam Are you Under a PHYSICIAN'S CARE NOW? Are you under a PHYSICIAN'S CARE NOW? Are you under a PHYSICIAN'S CARE NOW? WHAT? Are you UNHAPPY with your dentures? What? What MEDICATIONS are you currently taking? What? What MEDICATIONS are you currently taking? What we you wear DENTURES? (Partials or full) Do you wear DENTURES? (Partials or full) PERMANENT REPLACEMENTS? Are you UNHAPPY with your dentures? Would you like to know more about PERMANENT REPLACEMENTS? Are you aware of GRINDING or CIENCHING your teeth? Do you aware DENTURES. (Partials or fire in temperature) Are you aware of GRINDING or CIENCHING your teeth? Are you aware of GRINDING or CIENCHING your teeth? Do you have BEED, or feel TENDER or IRRITATED? Are you aware of GRINDING or CIENCHING your teeth? Back problems Back p	POLICY HOLDER'S EMPLOYER										
MEMBER ID or SOCIAL SECURITY # GROUP # PHONE NO. It is important that we know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire. DENTAL HISTORY YES NO MEDICAL HISTORY YES NO Do you have seen a dentist? Date of last GOMPLETE Dental Exam Are you under a PHYSICIAN'S CARE NOW? Date of Last FULL MOUTH X-RAYS (as Small Files or Parocinic) For what? WHAT? Date of Last FULL MOUTH X-RAYS (as Small Files or Parocinic) For what? What? Have you wear DENTURES? (Partials or full) Brown were used a BISPHOSPHONATE MEDICATION? Are you UNHAPPY with your dentures? Do you wear DENTURES? (Partials or full) Brown were about dental treatment? Are you under a PHYSICIAN'S CARE NOW? Have you ever used a BISPHOSPHONATE MEDICATION? PERMANENT REPLACEMENTS? Are you PREGNANT? Do you use CIGARS, CIGARRETES, CHEWING TOBACCO, or a VAPE? (Crucia Denominal Control of Present Members of Pres											
RROUP # PHONE NO. PHONE NO. PHONE NO. PHONE NO. PHONE NO.											
It is important that we know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Dental History	MEMBER ID or SOCIAL SECURITY	#			MEMBER	ID or	r SOCIAL SECURITY #	·			
DEVITAL HISTORY YES NO MEDICAL HISTORY YES NO MEDICAL HISTORY YES NO DO you have any CURRENT HEALTH PROBLEMS? Date of last COMPLETE Dental Exam Date of last COMPLETE Dental Exam Are you under a PHYSICIAN'S CARE NOW? Date of last FULL MOUTH X-RAYS (as small Films or Panoramic) Are you having PROBLEMS now? Is your present dental health POOR? Do you wear DENTURES? (Partials or full) Are you UNHAPPY with your dentures? Do you wear DENTURES? (Partials or full) Are you UNHAPPY with your dentures? Do you gues DENTURES? (Partials or full) Are you UNHAPPY with your dentures? Do you gues DENTURES? (Partials or full) Are you DENTURES? (Partials or full) Are you under a PHYSICIAN'S CARE NOW? DO you wear DENTURES? (Partials or full) Are you under a PHYSICIAN'S CARE NOW? DO you wear DENTURES? (Partials or full) Are you under a PHYSICIAN'S CARE NOW? DO you used DENTURES? (Partials or full) Are you under a PHYSICIAN'S CARE NOW? DO you used DENTURES? (Partials or full) Are you under a PHYSICIAN'S CARE NOW? DO you used DENTURES? (Partials or full) Are you under a PHYSICIAN'S CARE NOW? DO you used DENTURES? (Partials or full) Are you under a PHYSICIAN'S CARE NOW? DO you used DENTURES? (Partials or full) Are you under a PHYSICIAN'S CARE NOW? DO you used DENTURES? (Partials or full) Are you under a PHYSICIAN'S CARE NOW? DO you used DENTURES? (Partials or full) Are you under a PHYSICIAN'S CARE NOW? DO you used DENTURES? (Partials or full) Are you under a PHYSICIAN'S CARE NOW? DO you used DENTURES? (Partials or full) Are you under a PHYSICIAN'S CARE NOW? DO you used DENTURES? (Partials or full) Are you under a PHYSICIAN'S CARE NOW? DO you used DENTURES? (Partials or full) Are you under a PHYSICIAN'S CARE NOW? PEASE* YES NO ANTE MEDICATIONS? DO you used DENTURES? (Partials or full) Are you under a PHYSICIAN'S CARE NOW? PEASE* YES SO NOO'NE ENDITE FULLOWARY (PES IF YOU HAVE HAD OR PRESENTY HAVE: DO you have HEADACHES, or NECK pressure, Arcials or full Medical Now YES NO ATTAINS (Partials or	GROUP #	PHONE NO			GROUP # .			PHONE NO)		
DENTAL HISTORY VES NO Do you have seen a dentist? Date of last COMPLETE Dental Exam Date of Last FULL MOUTH X-RAYS (as Small Farms or Parnoramic) Are you under a PHYSICIAN'S CARE NOW? For what? What? What MEDICATIONS are you currently taking? What MEDICATIONS are you currently										trictly	Y
Do you have any CURRENT HEALTH PROBLEMS? Date of last COMPLETE Dental Exam Are you under a PHYSICIAN'S CARE NOW? Date of Last FULL MOUTH X-RAYS [16 Small Films or Panoramic) Are you having PROBLEMS now? WHAT? Is your present dental health POOR? Is your present dental health POOR? By you war DENTURES? (Partials or full) Are you uNHAPPY with your dentures? Would you like to know more about PERMANENT REPLACEMENTS? Are you APPREHENSIVE about dental treatment? Are you aware of GRINDING or CLENCHING your teeth? Are you aware of GRINDING or CLENCHING your teeth? Do you worn BRACES on your teeth? Do you have DISCOLORED teeth that bother you? Name of Previous Dentist: City: State: How do you feel about your teeth? Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment (scale of 1 to 4) Fear: Trust: Do you ware not feel flato Exam Are you were on your teet (Panoramic) Are you not have have following in the order in which they would KEEP YOU FROM having dental treatment (scale of 1 to 4) Fear: Trust: Do you inder a PHYSICIAN'S CARE NOW? To you ware any CURRENT HEALTH PROBLEMS? To you ware PHYSICIAN'S CARE NOW? What Prove woulder a PHYSICIAN'S CARE NOW? What MEDICATIONS are you currently taking? What MEDICATIONS are you currently taking. What MEDICATIONS are					ior taking ui	e uiii				NO	_
Date of last COMPLETE Dental Exam Date of Last FULL MOUTH X-RAYS (1s small Films or Panoramic) Are you under a PHYSICIAN'S CARE NOW? For what? For what? What MEDICATIONS are you currently taking? Are you wear Dentrures? Do you wear DENTURES? (Partials or full) Are you UNHAPPY with your dentures? Would you like to know more about PERMANENT REPLACEMENTS? Are you APPREHENSIVE about dental treatment? Have you had any PERIODONTAL (GUM) treatments? Do your gums BLEED, or feel TENDER or IRRITATED? Are you ware of GRINDING or CLENCHING your teeth? Do you have HEADACHES, EARACHES, or NECK PAINS? Do you have HEADACHES, EARACHES, or NECK PAINS? Do you have DISCOLORED teeth that bother you? Do you REGULARLY use DENTAL FLOSS? City: State: How do you feel about your teeth? Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment (scale of 1 to 4) Fear: Trust: Trust: Are you under a PHYSICIAN'S CARE NOW? For what? For what?			120 110		ave any CURR	ENT		,			
Are you having PROBLEMS now?	Date of last COMPLETE Dental Exam			Are you u	nder a PHYSI	CIAN'	'S CARE NOW?				
Syour present dental health POOR?		Small Films or Panoramic)									
Is your present dental health POOR?				∫ What ME	DICATIONS ar	e you	u currently taking?				
Do you wear DENTURES? (Partials or full)				Have you	ever used a f	SISPE	HOSPHONATE MEDICATI	ON?			
Would you like to know more about PERMANENT REPLACEMENTS? Are you APPREHENSIVE about dental treatment? Have you had any PERIODONTAL (GUM) treatments? Are you reeth SENSITIVE to hot, cold, sweets, pressure? (circle) Are you ware of GRINDING or CLENCHING your teeth? Are you worn BRACES on your teeth? Do you have DISCOLORED teeth that bother you? Do you have DISCOLORED teeth that bother you? Do you REGULARLY use DENTAL FLOSS? Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment (scale of 1 to 4) Fear: Trust: Do you use CIGARS, CIGARETTES, CHEWING TOBACCO, or a VAPE? (circle) Do you use FIFFOLLOWING TOBACCO, or a VAPE? (circle) Do you use CIGARS, CIGARETTES, CHEWING TOBACCO, or a VAPE? (circle) Do you have HAVE YOU HAVE HAD OR PRESENTLY HAVE): PLEASE Y YES OR NO TO THE FOLLOWING TOBACCO, or a VAPE? (circle) YES NO YES NO AIDS/HIV Pos. FES OR NO TO THE FOLLOWING TOBACCO, or a VAPE? (circle) PLEASE Y YES OR NO TO THE FOLLOWING TOBACCO, or a VAPE? (circle) PLEASE Y YES OR NO TO THE FOLLOWING TOBACCO, or a VAPE? (circle) PELASE Y YES OR NO TO THE FOLLOWING TOBACCO, or a VAPE? (circle) PELASE Y YES OR NO TO THE FOLLOWING TOBACCO, or a VAPE? (circle) PELASE Y YES OR NO TO THE FOLLOWING TOBACCO, or a VAPE? (circle) PS NO YES NO AIDS/HIV Pos. AIDS/HIV Pos. APIPLASE Y YES OR NO TO THE FOLLOWING TOBACCO, or a VAPE? (circle) PS NO TEAS Y YES OR NO TO THE FOLLOWING TOBACCO, or a VAPE? (circle) ARE you ALERGIC TO THATE TO THATE TO THE FISCH TOWN TO THE FOLLOWING MEDICATIONS? (Circle) ARE you ALLERGIC TO RHAVE YOU REACTED TO ANY OF THE FOLLOWING MEDICATIONS? (Circle) ARE you ALLERGIC TO RHAVE YOU REACTED TO ANY OF THE FOLLOWING MEDICATIONS? (Circle) ARE you ALLERGIC TO RHAVE YOU REACTED TO ANY OF THE FOLLOWING MEDICATIONS? (Circle) ARE you ALLERGIC TO RHAVE YOU REACTED TO ANY OF THE FOLLOWING MEDICATIONS? (Circle) ARE you ALLERGIC TO RHAVE YOU REACTED TO ANY OF THE FOLLOWING MEDICATIONS? (Circle) ARE you ALLERGIC TO RHAVE YOU REACTED TO ANY OF TH		full)		(Brand námes	include Fosamax, Act	onel, At	telvia, Didronel and Boniva)				
PERMANENT REPLACEMENTS? Are you APPREHENSIVE about dental treatment? Are you APPREHENSIVE about dental treatment? Are you had any PERIODONTAL (GUM) treatments? Do your gums BLEED, or feel TENDER or IRRITATED? Are you reteth SENSITIVE to hot, cold, sweets, pressure? (circle) Are you aware of GRINDING or CLENCHING your teeth? Are you worn BRACES on your teeth? Do you have DISCOLORED teeth that bother you? Do you REGULARLY use DENTAL FLOSS? Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment (scale of 1 to 4) Fear: Trust: Trust: PLEÁSE Y YES OR NO TO THE FOLLOWING (YES IF YOU HAVE HAD OR PRESENTLY HAVE): YES NO Anaphylaxis Fainting Peadcaton Peycintromycin Latex (Ballons, gloves) Nitrous Oxide Codeine Penicillin Are you aware of being allergic to any other medications, substances, materials or foods? If so, please ist or write NONE:		?				CADI	ETTES CHEWING TORAC	200 or a \/ADE			
Are you APPREHENSIVE about dental treatment?	1										
Have you had any PERIODONTAL (GUM) treatments?		treatment?		AIDS/HIV	, D		**		iatric care		
Do your gums BLEED, or feel TENDER or IRRITATED? Are your teeth SENSITIVE to hot, cold, sweets, pressure? (orde) Are you aware of GRINDING or CLENCHING your teeth? Do you have HEADACHES, EARACHES, or NECK PAINS? Have you worn BRACES on your teeth? Do you have DISCOLORED teeth that bother you? Would you like your smile to LOOK BETTER or DIFFERENT? Do you REGULARLY use DENTAL FLOSS? Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment (scale of 1 to 4) Fear: Trust: Are you worn BRACES or look, cold, sweets, pressure? (orde) Arthirits Heart Murmur Heart Murmur Respiratory disease Heart Murmur Respiratory disease Glaucoma Respiratory disease Respiratory disease Glaucoma Respiratory disease Coescribe Skin rash Glaucoma Heart Murmur Heart Murmur Heart Murmur H	-									in □	
Artificial heart valves Heart Murmur Rheumatic/scarlet fever Heart Murmur Rheumatic/scarlet fever Heart problems Shingles Shingles Heave you ware of GRINDING or CLENCHING your teeth? Heart problems Shingles Shingles Heave you ware places on your teeth? Heart problems Shingles Shingles Heave you ware places on your teeth? Hemophilia Skin rash Back problems Hemophilia Skin rash Herpes Stroke Herpes Herpes Herpes Stroke Herpes Stroke Herpes Her	, ,							☐ ☐ Radia	tion treatmen [.]	t 🗆	
Artificial joints Heart problems Shingles Do you have HEADACHES, EARACHES, or NECK PAINS? Heave you worn BRACES on your teeth? Back problems Hemophilia Skin rash Back problems Hemophilia Skin rash Skin rash Back problems Hemophilia Skin rash Back problems Skin rash Back problems Skin rash Back problems Hemophilia Skin rash Back problems Hemophilia Skin rash Back problems Hemophilia Skin rash Back problems Skin rash Back problems Hemophilia Hemophilia Back problems Hemophilia Hemophilia Back problems Hemophilia Hemophilia Back pr	Are your teeth SENSITIVE to hot, cold,	sweets, pressure?	Circle)								
Have you worn BRACES on your teeth? Do you have DISCOLORED teeth that bother you? Would you like your smile to LOOK BETTER or DIFFERENT? Do you REGULARLY use DENTAL FLOSS? Name of Previous Dentist: City: State: How do you feel about your teeth? Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment (scale of 1 to 4) Fear: Trust: Back problems Hemophilia Skin rash Glood disease Herpes Stroke Glood disease Herpes Stroke Glood disease Herpes Stroke Glood disease Herpes Stroke Glood disease Glood disease Herpes Stroke Glood disease Glood disease Glood disease Herpes Stroke Glood disease Glood disease Herpes Stroke Glood disease Glood d	Are you aware of GRINDING or CLENC	HING your teeth?						☐ ☐ Shing	es		
Do you have DISCOLORED teeth that bother you? Would you like your smile to LOOK BETTER or DIFFERENT? Do you REGULARLY use DENTAL FLOSS? Name of Previous Dentist: City: State: How do you feel about your teeth? Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment (scale of 1 to 4) Fear: Trust: Blood disease Herpes Stroke Cancer High blood pressure Surgical implant Swelling of feet or ankles Chemical dependency Jaw pain Swelling of feet or ankles Chemical dependency Jaw pain Swelling of feet or ankles Chemical dependency Jaw pain Swelling of feet or ankles Chemical dependency Jaw pain Swelling of feet or ankles Chemical dependency Jaw pain Swelling of feet or ankles Chemical dependency Swelling of feet or ankles Chemical dependency Mitral valve prolapse Thyroid disease Tonsillitis Cortisone treaments Mitral valve prolapse Tuberculosis Diabetes Pacemaker/heart Surgery ARE YOU ALLERGIC TO OR HAVE YOU REACTED TO ANY OF THE FOLLOWING MEDICATIONS? (Circle) Aspirin Local Anesthetic Erythromycin Latex (Ballons, gloves) Nitrous Oxide Codeine Penicillin Are you aware of being allergic to any other medications, substances, materials or foods? If so, please list or write NONE:	Do you have HEADACHES, EARACHES	, or NECK PAINS?					(Describe)	~		_	
Do you have DISCOLORED teeth that bother you? Would you like your smile to LOOK BETTER or DIFFERENT? Do you REGULARLY use DENTAL FLOSS? Name of Previous Dentist: City: State: How do you feel about your teeth? Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment (scale of 1 to 4) Fear: Trust: Trust: High blood pressure Surgical implant Chemical dependency Jaw pain Swelling of feet or ankles Chemotherapy Kidney disease Thyroid disease Thyroid disease Circulatory problems Liver disease Thyroid disease Thyroid disease Cortisone treaments Mitral valve prolapse Tuberculosis Diabetes Pacemaker/heart Surgery Witrous problems Ulcer/Colitis Diabetes Pacemaker/heart Aspirin Local Anesthetic Erythromycin Latex (Ballons, gloves) Nitrous Oxide Codeine Penicillin Are you aware of being allergic to any other medications, substances, materials or foods? If so, please list or write NONE:											
Do you REGULARLY use DENTAL FLOSS? Chemotherapy	· · · · · · · · · · · · · · · · · · ·			Cancer			☐ High blood pressure	□ □ Surgio			
Name of Previous Dentist: City: State: How do you feel about your teeth? Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment (scale of 1 to 4) Fear: Trust: Circulatory problems Liver disease Tonsillitis Cortisone treaments Mitral valve prolapse Tuberculosis Diabetes Pacemaker/heart Surgery Please RANK the following in the order in which they would Aspirin Local Anesthetic Erythromycin Latex (Ballons, gloves) Nitrous Oxide Penicillin Are you aware of being allergic to any other medications, substances, materials or foods?											
City: State: How do you feel about your teeth? Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment (scale of 1 to 4) Fear: Trust: Cortisone treaments Mitral valve prolapse Tuberculosis Daberculosis Daberculosis Diabetes Daberculosis Diabetes Daberculosis Dabetes Dabe	-	SS?						□ □ Inyroi	u uisease litis		
How do you feel about your teeth? Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment (scale of 1 to 4) Fear: Trust: Diabetes Pacemaker/heart surgery surgery ARE YOU ALLERGIC TO OR HAVE YOU REACTED TO ANY OF THE FOLLOWING MEDICATIONS? (Circle) Aspirin Local Anesthetic Erythromycin Latex (Ballons, gloves) Nitrous Oxide Codeine Are you aware of being allergic to any other medications, substances, materials or foods? If so, please list or write NONE:				Cortisone	e treaments		 Mitral valve prolapse 	□ □ Tuber	culosis		
Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment (scale of 1 to 4) Fear: Trust: Surgery ARE YOU ALLERGIC TO OR HAVE YOU REACTED TO ANY OF THE FOLLOWING MEDICATIONS? (Circle) Aspirin Local Anesthetic Erythromycin Latex (Ballons, gloves) Nitrous Oxide Codeine Are you aware of being allergic to any other medications, substances, materials or foods? If so, please list or write NONE:	,								COIITIS		
KEEP YOU FROM having dental treatment (scale of 1 to 4) Fear: Trust: Aspirin Local Anesthetic Erythromycin Latex (Ballons, gloves) Nitrous Oxide Codeine Are you aware of being allergic to any other medications, substances, materials or foods? If so, please list or write NONE:		order in which the	אַרווא		'		surgery		TIONICO (OL		
Fear: Trust: Are you aware of being allergic to any other medications, substances, materials or foods? If so, please list or write NONE:	_	•								Penic	cillin
ii oo, piedoe iide or winte Norte.		Table of T		Are you awa	are of being alle	rgic to					
TAIVILLE FRI SICIAL FROM FROM INC.						INE.		DHONE NO			
	Time.			1.7.441121 [1							_

PRIVACY NOTICE

This notice describes how information about you may be used and disclosed and how you can get access to this information when necessary. Please review it carefully.

Introduction

At Towne Centre Family Dental and the Implant and SmileMakeover Studio, we are committed to treating information about you and your health responsibly. This notice of health information practices describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your protective health information. This notice is effective September 1, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record and Information

Each time you visit Towne Centre Family Dental and the Implant and SmileMakeover Studio, a record of your visit is made. Typically, this record contains your symptoms, examination, diagnoses, treatment, lab results, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as:

- A basis for planning your care and treatment
- A means of communication among many health professionals who contribute to your care
- · A legal document describing the care you received
- A means by which a third-party payer can verify that services were actually provided
- · A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials
- · A source of data for our planning and marketing
- A tool with which we can access and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Towne Centre Family Dental and the Implant & SmileMakeover Studio, the information belongs to you. You have the right to:

- · Inspect and copy your health record
- · Amend your health record
- Obtain an accounting of disclosures of your health information
- · Request communications of your health information by alternative means or at alternative locations
- Request a restriction on certain uses and disclosures of your information
- · Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

Patient Name:

Date:

Towne Centre Family Dental and the Implant & SmileMakeover Studio are required to:

- Maintain the privacy of your health information
- · Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- · Abide by the terms of this notice

information:

- Notify you if we are unable to agree to a requested restriction
- · Accommodate reasonable requests you may have to communicate health information by alternative means or at alternate locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us, or if you agree, we will e-mail the revised notice to you. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization. For more information, please contact our privacy officer, Nancy, at 908-874-4555.

By signing this form, you acknowledge that Towne Centre Family Dental and the Implant & SmileMakeover Stud
has given your a copy of its Drivocy Notice, which explains how your health information will be handled in various

By signing this form, you acknowledge that Towne Centre Family Dental and the Implant & SmileMakeover Studio has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations.

By sig	gning, I assert that the following are true:
~	I have received Towne Centre Family Dental's Privacy Notice.
~	Towne Centre Family Dental has given me the chance to discuss my concerns and questions about
	the privacy of my health information.
~	I wish to place the following restrictions on the use and/or disclosure of my personal health

Signature	Date	

NEW PATIENT QUESTIONNAIRE

lf you a	re having	g a dent	al prob	lem,
please	circle yo	ur area	of con	cern

Upper Left	Upper Right	□ Not applicable
Lower	Lower	
Left	Right	

1. What is your pain leve	el on a scale froi	n 0 (none) to	10 (most) 0	-123456-	78910
If in pain, how fre	equent? (circle)	Occas	ionally 🗆	Daily □	Constant □
2. Your perception of your Excellent			□ Poor		
3. How is your chewing	ability?				
□ Eating is very d□ There are certaExample□ There are no lir	nin foods that I es:	can't eat no	ormally	eeth 	
4. How do you feel abou ☐ I've always hop ☐ My smile is not ☐ I like my smile a	ed that somet ideal, but it is	hing could b not a priorit	e done to imp ty at this time	•	

FOR IMPLANT CONSULTATION PATIENTS ONLY

1. Upon completion of your implant treatment, you would expect the following:

Esthetics (choose one)

☐ A beautiful, white smile- everyone notices
☐ A natural smile- healthy looking, people will notice I look better but may not know why

☐ The appearance of my smile is not that important

Function

My expectation of full chewing upon completion (circle): Soft Foods Only 0----1----2----3-----5-----6----7----8-----9

2. Upon completion of implant treatment:

☐ It's important that any tooth replacement is not able to be removed (fixed)

 $\hfill\square$ Removable teeth like a partial or denture are okay, as long as they are comfortable

PATIENT CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the 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 made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports may be obtained.

Signat	ureDate
	PRE-AUTHORIZED CARD ON FILE FORM
I autho	orize Towne Centre Family Dental to keep my signature on file and to charge my credit/debit card account as indicated
	ayments, Deductibles, Coinsurance, and Product/Supplement fees due at time of service ince of charges not paid by the insurance or by myself after 30 days of receipt of explanation of benefits
Card Ir	nformation:
	Card Type (Circle): VISA / MASTERCARD / AMEX Name on Card: Billing Zip Code: Card Number: CVV: Expiration Date: CVV:
Name(I unde unless be fille	elist anyone other than the cardholder who is authorized to use this credit/debit card. (s): rstand this credit/debit card will be kept on file and will remain in effect until the expiration of the credit card account otherwise stated. This credit card on file may be removed at any time by submitting a written request. A new form must dout if any information such as credit/debit card number or authorized users is amended. I agree to pay the cost for any ed or challenged payments.
Signat	ureDate
I unde	PHOTOGRAPHY RELEASE hereby authorize Dr. Albert Internoscia, associates, and staff to take photographs, slides, and/or of my face, jaws, and teeth. rstand that the photographs, slides, and/or videos will be used as a record of my care and may be used for education ses in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, video-DVDs, television), and professional publications (dental magazines and journals).
publica	er understand that if these photographs, slides, and/or videos are used in any ation or as part of a demonstration, my full name or other identifying information will be kept confidential. I do not expect ensation, financial or otherwise, for the use of these materials.

Date

Signature