Patient Information		Patient	Information		
Date		Who is responsible for this account?			
SS/HIC/Patient ID #		Relationship to Patient			
Patient Name					
Last Harris		City	State Zip		
First Name	Middle Initial	Insurance Co	Group #		
Address		Is patient covered by additional Insurance?    Yes   No			
E-mail		Subscriber's Name			
City		Birthdate	SS#		
StateZip		Relationship to Patien	t		
Sex M F Age		Insurance Co			
Birthdate		Group #			
☐ Married ☐ Widowed ☐ Sing	gle  Minor	ASSIGNMENT AND REL	EASE		
☐ Separated ☐ Divorced ☐ Part	tnered foryears		my dependent(s), have insurance of	coverage with	
Patient Employer/School		and assign directly to			
Occupation		Name of Insurance Company(ies)			
rendered. I u		rendered. I understand th	rchant all insurance benefits, If any, otherwise payable to me for services ed. I understand that I am financially responsible for all charges whether or not y insurance, I authorize the use of my signature on all Insurance submissions.		
Employer/School Phone ()		information to the above	t may use my health care information ar e-named Insurance Company(ies) and	their agents for the	
		purpose of obtaining pay benefits payable for relate	ment for services and determining insu ed services.	rance benefits or the	
Spouse's Name					
Birthdate		Signature of Pa	tient, Parent, Guardian or Personal Rep	resentative	
		Please print name of	of Patient, Parent, Guardian or Personal	Representative	
Spouse's Employer		riodoo print ridino o	Tration, Faront, adardian or Forochar	rioprocentative	
Whom may we thank for referring you?		Date	Relationship to Patient		
Phone Numbers					
Home ()			Cell Phone ()		
Spouse's Work ()					
Home Phone ()		Vork Phone ()			
Dental History					
-					
Reason for today's visit			Mouth breathing	Yes No	
	Cigarette pipe or cigar smo	Yes No No No No	Mouth pain, brushing Orthodontic treatment	☐ Yes ☐ No☐ Yes ☐ No	
Former Dentist	Clicking or popping jaw	☐ Yes ☐ No	Pain around ear	Yes No	
City/State	Financial biting	Yes No	Periodontal treatment	Yes No	
Date of last dental visit	Food collection between the	☐ Yes ☐ No teeth ☐ Yes ☐ No	Sensitivity to cold Sensitivity to heat	☐ Yes ☐ No☐ Yes ☐ No	
Date of last dental X-rays	Foreign objects	☐ Yes ☐ No	Sensitivity to sweets	Yes No	
Place a mark on "yes" or "no" to indicate if have had any of the following:	you Grinding teeth Gums swollen or tender	Yes No	Sensitivity when biting	Yes No	
Bad breath		Yes No	Sores or growth in your mouth  How often do you floss?		
Bleeding gums	☐ No Lip or cheek biting	Yes No			
Blister on lips or mouth	■ No Loose teeth or broken fillings	Yes No	How often do you brush?		

Health Histo	ory					
N. A.						
Physician's Name			phon0" Those include cor	mbinations of Ionimin, Adipex, F	antin /laward manage of	
phentermine.) Pondimin (fenflu				nbinations of ionimin, Adipex, F	astin (brand names of	
	,	, – –				
Place a mark on "yes" or "no"	*	,				
AIDS/HIV	Yes No	Epilepsy	Yes No	Respiratory Disease	Yes No	
Anemia	Yes No	Fainting or dizziness	Yes No	Rheumatic Fever	Yes No	
Arthritis, Rheumatism	Yes No	Glaucoma	Yes No	Scarlet Fever	Yes No	
Artificial Heart Valves	Yes No	Headaches Heart Murmur	☐ Yes ☐ No ☐ Yes ☐ No	Shortness of Breath Sinus Trouble	Yes No	
Artificial Joints	Yes No	Heart Problems	Yes No	Skin Rash	Yes No	
Asthma Back Problems	☐ Yes ☐ No☐ Yes ☐ No	Hepatitis Type		Special Diet	Yes No	
Bleeding abnormally, with	Tes INO	Herpes	☐ Yes ☐ No	Stroke	Yes No	
extractions or surgery	Yes No	High Blood Pressure	Yes No	Swollen Feet or Ankles	Yes No	
Blood Disease	Yes No	Jaundice	Yes No	Swollen Neck Glands	Yes No	
Cancer	Yes No	Jaw Pain	Yes No	Thyroid Problems	☐ Yes ☐ No	
Chemical Dependency	Yes No	Kidney Disease	Yes No	Tonsillitis	Yes No	
Chemotherapy	Yes No	Liver Disease	Yes No	Tuberculosis	Yes No	
Circulatory Problems	Yes No	Low Blood Pressure	☐ Yes ☐ No	Tumor or growth on head		
Congenital Heart Lesions	Yes No	Mitral Valve Prolapse	Yes No	or neck	Yes No	
Cortisone Treatments	Yes No	Nervous Problems	Yes No	Ulcer Venereal Disease	Yes No	
Cough, persistent or bloody		Pacemaker	Yes No	Weight Loss, unexplained	Yes No	
Diatbetes	Yes No	Psychiatric Care	Yes No	weight Loss, unexplained	Tes Tivo	
Emphysema	Yes No	Radiation Treatment	Yes No			
Do you wear contact lenses? Women:	Yes No					
Are you pregnant?  Yes	□ No	Due date	Are you n	ursing?  Yes  No		
Taking birth control pills?		Due date	Are you no	drsing? Thes Tho		
raiding billing control pillot.	100 🗖 110					
N	ledications		Privacy I	Practices Acknowled	lgement	
List any medications you are o	currently taking and	the correlating diagnosis:		tice of Privacy Practices and I ha	ave been provided an	
			opportunity to review in			
			Patient			
Pharmacy Name		(Please Print) Signature Date				
Phone ()		Signature Date				
	Allergies		I declare the above info	ormation to be correct and hold	Dr. Merchant	
Allergies			blameless in the event of any problems or injury that may occur from			
				or omission of facts. I understan		
Yes No Aspirin	☐ Yes	No Local Anesthetic		e time rendered, unless other an uld financial arrangements be m		
Yes  No Barbiturates (S	leeping pills)	No Penicillin	an additional 1.5% per	month of any unpaid balance. I	agree to pay an	
☐ Yes ☐ No Codeine	additional \$20.00 for any about that I may write that is returned Chauld I					
☐ Yes ☐ No Iodine		ner		cial agreements, I snall pay an a ay become necessary in collect		
Yes No Latex			and logar loos which h	ay become necessary in concer	ion or this account.	
	A *		Signature	Date		
Undates u	be filled in at	future appointment)				
C States in	be filled in at	ruture appointment				
Has there been any change in	vour health since vo	our last dental appointment	☐ Yes ☐ No			
For what conditions?			<b>1</b> 103 <b>1</b> 110			
Patient's Signature						
				Date		
•••••	•••••	•••••	•••••	•••••	•••••	
Has there been any change in		ur last dental appointment?	Ves No			
	your nealth since yo	di last deritai appointment:	<b>1</b> 103 <b>1</b> 110			
For what conditions?						
Are you taking any new medica	ations?	If so, what?				
	ations?	If so, what?				