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.

Address			Patient #
Name Birthdate Home Phone Address City PPC Email Cold Phone Cold Phone Cacke Appropriate Box: Minor Single Married Divorced Widowed Separated Fistige City Prov. Time Prov. Time Prov. Address City Prov. Prov. Prov. Prov. Prov. Spouse or Paront/Guardian's Name Employer Work Phone Spouse or Paront/Guardian's Name Employer Whom may we thank for referring you? Phone Phone Phone Responsible Party Relationship to Putient Address Enail Call Phone Employer Work Phone States Home Phone Employer Phone Responsible Party Relationship to Putient Address Enail Call Phone SS#/SIN State	D. C. C.		SS#/SIN
Name Birthdate Home Phone Address City Prov. Prov. Email City Prov. Prov. Prov. Cacke Appropriate Box: Minor Single Married Divorced Widowed Separated Full Port If Student, Name of School/College City Prov. Pitter Pitt	Patient Information	Date	
Email Cell Phone Check Appropriate Box: Minor Single Married Divorced Widewed Separated If Student, Name of School/College City Prov. Full Part Patient or Parent/Guardian's Employer Work Phone Separated Full Part Address City Prov. Prov. Prov. Prov. Spouse or Parent/Guardian's Name Employer Work Phone Prov. Prov. Prov. Spouse or Parent/Guardian's Kame Employer Work Phone Prov. Prov. Prov. Spouse or Parent/Guardian's Kame Employer Work Phone Prov. Prov. Prov. Responsible Party Name of Person Responsible for this Account Relationship to Patient Phone			Home Phone
Check Appropriate Box: Minor Single Married Divorced Sequented Se	Address	City	Prov P. C
If Student, Name of School/CollegeCityProvTimeTimeTimeTimeTimeTimeTimeTimeTimeTimeTimeTimeTimeTimeTime	Email		Cell Phone
Patient or Parent/Guardian's Employer Work Phone Address City Fro. Spouse or Parent/Guardian's Name Employer Work Phone Whom may we thank for referring you? Phone Phone Responsible Party Relationship to Patient Name of Person Responsible for this Account to Patient to Patient Address Home Phone Phone Email Cell Phone Cell Phone Driver's License # Birthdate Financial Institution Employer Work Phone SS#/SIN Is this person currently a patient in our office? Yes No For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment. Cash Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy. Insurance Information Relationship Date Employed Yep, Name of Insured Is S#/SIN Date Employed Pro. Name of Insured SS#/SIN Date Employed Yep, Name of Employer City Pro. <t< td=""><td>Check Appropriate Box: 🛛 Minor</td><td>\Box Single \Box Married \Box Divorced \Box Wi</td><td>dowed State/ Full Part</td></t<>	Check Appropriate Box: 🛛 Minor	\Box Single \Box Married \Box Divorced \Box Wi	dowed State/ Full Part
Spoise or Parent/Guardian's Name Employer Work Phone Person to contact in case of emergency Phone Phone Responsible Party Relationship to Partient Name of Person Responsible for this Account Home Phone Relationship Address Home Phone Phone Email Cell Phone Cell Phone Driver's License # Birthdate Financial Institution Employer Work Phone SS#/SIN Is this person currently a patient in our office? Yes No For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment. Cash Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy. Insurd SS#/SIN Date Employed Nome of Insured Vork Phone State Name of Insured SS#/SIN Date Employed Nome of Phone Zip/ Name of Insured SS#/SIN Date Employed Nome of Phone Zip/ Insurance Company Group # Policy/ID # Zip/ Zip/ Insurance Company			
Spoise or Parent/Guardian's Name Employer Work Phone Person to contact in case of emergency Phone Phone Responsible Party Relationship to Partient Name of Person Responsible for this Account Home Phone Relationship Address Home Phone Phone Email Cell Phone Cell Phone Driver's License # Birthdate Financial Institution Employer Work Phone SS#/SIN Is this person currently a patient in our office? Yes No For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment. Cash Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy. Insurd SS#/SIN Date Employed Nome of Insured Vork Phone State Name of Insured SS#/SIN Date Employed Nome of Phone Zip/ Name of Insured SS#/SIN Date Employed Nome of Phone Zip/ Insurance Company Group # Policy/ID # Zip/ Zip/ Insurance Company	Patient or Parent/Guardian's Employer		Work Phone
Spoise or Parent/Guardian's Name Employer Work Phone Person to contact in case of emergency Phone Phone Responsible Party Relationship to Partient Name of Person Responsible for this Account Home Phone Relationship Address Home Phone Phone Email Cell Phone Cell Phone Driver's License # Birthdate Financial Institution Employer Work Phone SS#/SIN Is this person currently a patient in our office? Yes No For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment. Cash Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy. Insurd SS#/SIN Date Employed Nome of Insured Vork Phone State Name of Insured SS#/SIN Date Employed Nome of Phone Zip/ Name of Insured SS#/SIN Date Employed Nome of Phone Zip/ Insurance Company Group # Policy/ID # Zip/ Zip/ Insurance Company	Address	City	
Person to contact in case of emergency Phone Responsible Party Relationship Name of Person Responsible for this Account Relationship Address Home Phone Email Cell Phone Driver's License # Birthdate Financial Institution Employer Employer Work Phone SS#/SIN Is this person currently a patient in our office? Provier's License # Birthdate Employer Work Phone SS#/SIN Is this person currently a patient in our office? Provier ontwence, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment. Cash Personal Check The particular and the policy. Is work Phone Mame of Insured Relationship Is no of Insured Is Patient Name of Employer Union or Local # Work Phone Address of Employer Group # Policy/ID # Insurance Company Group # Policy/ID # Ins. Co. Address City Prov. PrC. How much have you used? Max. annual benefit DO YOU			
Responsible Party Relationship Name of Person Responsible for this Account to Patient Address Home Phone Email Cell Phone Driver's License # Birthdate Financial Institution Employer Work Phone SS#/SIN Is this person currently a patient in our office? Yes No For your convenience, we offer the following methods of payment. Please check the option you prefet: Payment in full at each appointment. SS#/SIN I Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy. Insurance Insured Credit Card VISA MasterCard I wish to discuss the office's payment policy. Mame of Insured SS#/SIN Date Employed Name of Employer Union or Local # Work Phone Matersa of Employer Group # Policy/ID # Insurance Company Group # Policy/ID # Insurance Company How much have you used? Max. annual benefit DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No If YES, COMPLETE THE FOLLOWING: Name of Insured SS#/SIN Date Employed	Whom may we thank for referring you?		
Name of Person Responsible for this Account Institution Address Home Phone Email Cell Phone Driver's License # Birthdate Employer Work Phone SS#/SIN Is this person currently a patient in our office? Is this person currently a patient in our office? Yes No No For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment. Cash Personal Check Credit Card VISA Mame of Insured Relationship Dirthered SS#/SIN Name of Insured SS#/SIN Date Employer EV Name of Employer Union or Local # Work Phone State/ Zip/ Pro. Insurance Company Group # Group # Policy/ID # State/ Pro. Pro. Pro. How much have you used? Max. annual benefit DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No Birthdate SS#/SIN Date Employed Na			Phone
Name of Person Responsible for this Account International processing of the procesis of the procesing of the processing of the p	Responsible Party	7	
Address Home Phone Email Cell Phone Driver's License # Birthdate Financial Institution Employer Work Phone SS#/SIN Is this person currently a patient in our office? Yes No For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment. Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy. Insurrance Information Relationship to Patient Relationship Name of Insured SS#/SIN Date Employed Name of Employer Union or Local # Work Phone Zip/ Address of Employer Group # Policy/ID # Zip/ Insurance Company Group # Policy/ID # Zip/ Insurance Company How much have you used? Max annual benefit Do YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING: Name of Insured SS#/SIN Date Employed Name of Employer Union or Local # Work Phone Name of Insured SS#/SIN Date Employed Nameo	1		Relationship to Patient
Email Cell Phone Driver's License # Birthdate Financial Institution Employer Work Phone SS#/SIN Is this person currently a patient in our office? Yes No For your convenience, we offer the following methods of payment. Please check the option you prefer Payment in full at each appointment. Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy. Insurance Information Relationship Relationship Relationship Name of Insured SS #/SIN Date Employed Prov. PC. Name of Employer City Prov. PC. Prov. PC. Insurance Company Group # Policy/ID # Zip/ Prov. PC. How much is your deductible? How much have you used? Max. annual benefit Do YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING: Name of Employer SS #/SIN Date Employed Name of Insured SE #/SIN Date Employed Insurance Company Group # No IF YES, COMPLETE THE FOLLOWING: Name of Insured City Prov. PC.			
Driver's License # Birthdate Financial Institution Employer Work Phone SS#/SIN Is this person currently a patient in our office? Yes No For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment. Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy. Insurance Information Relationship to Patient Date Employed Name of Insured SS#/SIN Date Employed Name of Employer Union or Local # Work Phone State' Zip/ Prov. PC. Insurance Company Group # Policy/ID # More much is your deductible? How much have you used? Max. annual benefit DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING: Name of Employer SS#/SIN Date Employed Name of Employer Union or Local # Work Phone State/ Zip/ Prov. PC. Insurance Company Group # Do PolucyID # Name of Insured <			
Employer			
Is this person currently a patient in our office? Yes No For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment. Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy. Insurance Information SS#/SIN Date Employed Name of Employer City Prov. PrC. How much is your deductible? How much have you used? Max. annual benefit DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING: Name of Employer Union or Local Work Phone SS#/SIN Date Employed Name of Insured Employer City Prov. PrC. How much is gour deductible? Yes No SS#/SIN Do IF YES, COMPLETE THE FOLLOWING: Name of Employer City Prov. PrC. Name of Insured SS#/SIN Date Employed Name of Employer City Prov. PrC. Name of Employer City Prov. PrC. Name of Insured Company City Prov. PrC. Name of Insured City Prov. PrC. Name of Employer City Prov. Prov. PrC. Name of Employer City Prov. Prov. Prov. PrC. Name of Employer City Prov. Prov. PrC. Name of Employer City Prov. Prov. Prov. PrC. Name of Employer City Prov. Prov. PrC. Name of Employer City Prov. Prc. Prov.			
Birthdate SS#/SIN Date Employed Name of Employer Union or Local # Work Phone Address of Employer City Prov. P.C. Insurance Company Group # Policy/ID # Ins. Co. Address City Prov. P.C. How much is your deductible? How much have you used? Max. annual benefit DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING: Name of Insured SS#/SIN Date Employed Name of Employer Union or Local # Work Phone Name of Employer City Prov. P.C. Insurance Company SS#/SIN Date Employed Name of Employer Union or Local # Work Phone Sitate SI SI Prov. P.C. Insurance Company Group # Policy/ID # Prov. P			Relationship
Name of Employer Union or Local # Work Phone Address of Employer City Prov. PC. Insurance Company Group # Policy/ID # Ins. Co. Address City Prov. PC. How much is your deductible? How much have you used? Max. annual benefit DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING: Name of Insured SS#/SIN Date Employed Name of Employer Union or Local # Work Phone Address of Employer City Prov. PC. Insurance Company SS#/SIN Date Employed Mork Phone Name of Employer City Prov. PC. Insurance Company Group # Policy/ID # PC. Insurance Company Group # Policy/ID # PC. Insurance Company Group # Policy/ID # PC. Insurance Company City Prov. PC. Insurance Company City Prov. PC. Insurance Company City Prov. PC. Ins. Co. Address			
Address of Employer City State/ Zip/ Insurance Company Group # Policy/ID # Ins. Co. Address City Prov. Prov. How much is your deductible? How much have you used? Max. annual benefit DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING: Name of Insured SS #/SIN Date Employed Name of Employer Union or Local # Work Phone Address of Employer City Prov. Prov. Name of Employer City Prov. Prov. Address of Employer City Prov. Prov. Insurance Company Group # Policy/ID # State/ Zip/ Ins. Co. Address City Prov. Prov. Prov. Prov.			
Insurance Company Group # Policy/ID # Ins. Co. Address City Prov. Prov. How much is your deductible? How much have you used? Max. annual benefit DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING: Name of Insured SS#/SIN Date Employed Name of Employer Union or Local # Work Phone Address of Employer City Prov. PC. Insurance Company Group # Policy/ID # Insurance Company Group # Policy/ID # Insurance Company City Prov. PC.			State/ Zip/
Ins. Co. Address City Prov.	Address of Employer	City	
How much is your deductible?			Policy/ID # State/ Zip/
DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING: Name of Insured			
Name of Insured Relationship to Patient BirthdateSS#/SIN Date Employed Name of Employer Union or Local # Address of Employer City Insurance Company Group # Ins. Co. Address City	How much is your deductible?	How much have you used?	Max. annual benefit
Name of Insured to Patient * Birthdate SS#/SIN Name of Employer Date Employed Address of Employer City Insurance Company Group # Policy/ID # State/ Zip/ State/ Zip/ Prov. PC. Prov. PC. Prov. PC. Prov. PC. Prov. PC. Prov. PC.	DO YOU HAVE ANY ADDITIONAL I	NSURANCE? 🗌 Yes 🗌 No IF YES, Co	
Birthdate SS#/SIN Date Employed Name of Employer Union or Local # Work Phone Address of Employer City Prov. PC. Insurance Company Group # Policy/ID # State/ Zip/ Ins. Co. Address City Prov. PC. State/ Zip/	Name of Insured		Relationship to Patient
Address of Employer City Prov PC Insurance Company Group # Policy/ID # Ins. Co. Address City Prov PC			Date Employed
Insurance Company Policy/ID # Ins. Co. Address City	Name of Employer	Union or Local #	Work Phone
Insurance Company Group # Policy/ID # Ins. Co. Address City Prov. PC.	Address of Employer	City	State/ Zip/ Prov P.C
Ins. Co. Address City Prov PC			Policy/ID #
			State/ Zip/ Prov P.C
110w much is your acadelible? 110w much nuve you used? 1910x. annual Denemi			

Patient Medical History

Yes No 1. Are you under medical treatment now? Image: Displace in the image: Displace in		No
surgical operation or serious illness within the last 5 years? If yes, please explain		_
If yes, please explain Penicillin or any other Antibiotics		
3. Are you taking any medication(s) Sulfa Drugs including non-prescription medicine? Barbiturates If yes, what medication(s) are you taking? Iodine 4. Have you ever taken Fen-Phen/Redux? Any Metals (e.g. nickel, mercury, etc.)		
3. Are you taking any medication(s) Barbiturates including non-prescription medicine? Sedatives If yes, what medication(s) are you taking? Iodine 4. Have you ever taken Fen-Phen/Redux? Any Metals (e.g. nickel, mercury, etc.)		
including non-prescription medicine? Image: Sedatives If yes, what medication(s) are you taking? Iodine 4. Have you ever taken Fen-Phen/Redux? Image: Sedatives		
If yes, what medication(s) are you taking? Iodine 4. Have you ever taken Fen-Phen/Redux? Any Metals (e.g. nickel, mercury, etc.)		
4. Have you ever taken Fen-Phen/Redux?		
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer Latex Rubber		
medications containing bisphosphonates? Image: Containing bisphosphonates? 6. Have you taken Viagra, Revatio, Cialis or Levitra 12. Do you have a persistent cough or throat clearing not		
in the last 24 hours?		
7. Do you use tobacco?		
8. Do you use controlled substances?		
9. Do you have or have you had any of the following? b) Are you nursing?		
c) Are you taking oral contraceptives?		
Yes No Yes No	Yes	No
High Blood Pressure Heart Disease		
Heart Attack Cardiac Pacemaker		
Rheumatic Fever E E Heart Murmur E Stroke		
Swollen Ankles		
Fainting / Seizures Image: Frequently Tired Frequently Tired		
Asthma	_	
Low Blood Pressure		
Epilepsy / Convulsions Cancer Recent Weight Loss Recent Weight Loss Recent Weight Loss Recent Weight Loss Recent Weight Loss Recent Weight Loss Recent Weight Loss Recent Weight Loss Recent Weight Loss Recent Weight Loss Recent Weight Loss Recent Weight Loss Recent Weight Loss Recent Weight Loss Recent Weight Loss Recent Weight Loss Recent Weight Loss Recent Weigh		
Leukemia		
Diabetes Diabetes		
Kidney Diseases Image: Hepatitis / Jaundice Image: Respiratory Problems ANDS - HWL Is failure Image: Respiratory Problems Image: Respiratory Problems		H
AIDS or HIV Infection Image: Sexually Transmitted Disease Image: Mitral Value Prolapse Thyroid Problem Image: Stomach Troubles / Ulcers Image: Other Other		
Thyroid Problem Stomach Troubles / Ulcers Other		
Name of Previous Dentist and Location Date of Last Exam Date of Last Exam	Yes	No
1. Do your gums bleed while brushing or flossing?		
2. Are your teeth sensitive to hot or cold liquids/foods?		
3. Are your teeth sensitive to sweet or sour liquids/foods?		
4. Do you feel pain to any of your teeth?	_	
5. Do you have any sores or lumps in or near your mouth?		Г
6. Have you had any head, neck or jaw injuries?	_	
7. Have you ever experienced any of the following following following extractions?		
problems in your jaw? 13. Have you had any orthodontic treatment?		
Clicking 14. Do you wear dentures or partials?		
Pain (joint, ear, side of face)		
Difficulty in opening or closing		
Difficulty in chewing		
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 accurate	y ans	wered ing th

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 dential 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.

Signature of patient (or parent/guard	an if minor)	Date	
Doctor's Comments			
	Signature	Date	

PATTERSON OFFICE SUPPLIES 1.800.637.1140 051-1014/16306