

## PATIENT INFORMATION

y	
Name	
Address	Apt. #
City	Zip Code
How long at this address?_	
Telephone ( )	
E-mail	
:	DL#
. Age	Birthdate
· · · · · · · · · · · · · · · · · · ·	
Responsible Party (If sam	ne as above, please skip)
Name	
Address	Apt. #
City	Zip Code
How long at this address?_	
Telephone ( )	
E-mail	
	DL#
:	
•	Birthdate
<u>EMPLOYMENT</u>	
Occupation	
:	
•	Zip Code
:	Ext. #
:	Date
·	
/REFERENCES	
Name	
:	Apt. #
•	Zip Code
: *	2.p 0000
Name	
•	Apt. #
:	Zip Code
•	ZIP Godd
:	
•	
······································	)
EMERGENCY CONTACT	
Name	
:	Apt. #
: \(\tau_{\text{rank}}\)	Λρι. π
City	7in Codo
: *	Zip Code

GET	TING TO KNOW YOU	
Are th	here other members of your household wh	o are not patients at our office?
Yes_	No Please list names and relation	ship (son, daughter, husband):
	1:	2:
	3:	4:
How	did you hear about our office?	
	Doctor's Referral Doctor's Name	:
	Yellow Pages Printed Material	
	Insurance Plan Walk in Sign	Family or Friend
·	TV Radio Billboard	Website

``.,			
INSURANCE			
Primary Insurance			
Name			
Address			
City		_ Zip code	
Telephone ( )			
Employer			
		Group #	
Insurer's Name			
Insured's Soc Sec No		Birthdate	
Secondary Insurance			
Name			
		_ Zip Code	
Telephone ( )			
Employer			
		Group #	
Insured's Name			
Insured's Soc Sec #		Birthdate	
MANAGED CARE PLAN (HMC	))		
Plan Name			
Employer			
Insured's Name			
Insured's Soc Sec #			

- 1. I hereby certify that the above information is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid for by my insurance for whatever reason.
- 2. By signing below, I understand that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.
- 3. I hereby authorize payment directly to the dentist of the group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.
- 4. I understand that Total Care Dental provides business support services to independent dentists and recognize that this dental practice is owned and operated by an independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist nor Keivan Sarraf DDS, Inc or its subsidiaries is responsible for my dental treatment.

o	<b>~</b> .
Signature	Date

## **GENERAL HEALTH INFORMATION**

Alzheimer's Disease  O Yes O No  Diabetes  O Yes O No  Hepatitis A  O Yes O No  Rheumatic Fever  O Yes C Anaphylaxis  O Yes O No  Drug Addiction  O Yes O No  Hepatitis B or C  O Yes O No  Rheumatism  O Yes C Anaphylaxis  O Yes O No  Eastly Wounded  O Yes O No  Herpes  O Yes O No  Scarlet Fever  O Yes C Anapina  O Yes O No  Emphysema  O Yes O No  Herpes  O Yes O No  Shingles  O Yes O Anapina  O Yes O No  Emphysema  O Yes O No  Hilves or Rash  O Yes O No  Shingles  O Yes O No  Arthritis/Gout  O Yes O No  Excessive Bleeding  O Yes O No  Hilves or Rash  O Yes O No  Scikel Cell Disease  O Yes O No  Artificial Heart Valve  O Yes O No  Excessive Bleeding  O Yes O No  Hypoglycemia  O Yes O No  Spina Biffida  O Yes O No  Artificial Joint  O Yes O No  Excessive Thirst  O Yes O No  Hilves or Rash  O Yes O No  Spina Biffida  O Yes O No  Spina Biffida  O Yes O No  Hay Frequent Cough  O Yes O No  Leukemia  O Yes O No  Stomach/Intestinal Disease  O Yes O No  Breathing Problem  O Yes O No  Frequent Headaches  O Yes O No  Liver Disease  O Yes O No  Stroke  O Yes O No  Bruste Easily  O Yes O No  Galucoma  O Yes O No  Louk Blood Pressure  O Yes O No  Thyroid Disease  O Yes O No  Cancer  O Yes O No  Galucoma  O Yes O No  Mitral Valve Prolapse  O Yes O No  Thyroid Disease  O Yes O No  Chemotherapy  O Yes O No  Heart Attack/Failure  O Yes O No  Parathyroid Disease  O Yes O No  Tumors or Growths  O Yes O No  Congenital Heart Disorder  O Yes O No  Heart Attack/Failure  O Yes O No  Parathyroid Disease  O Yes O No  Y	Date:									
whough dental personnel primarily treat the area in and around your mouth. your mouth is a part of your entire body. Health problems that you me medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Triank you for answering the followed control of the problems that you me medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Triank you for answering the followed control of the problems that you may be taking any medications and a major operation? O Yes O No If yes, please explain:  Have you ever had a serious head or neck injury? O Yes O No If yes, please explain:  Do you take, or have you taken, Priem-Fen or Redux? O Yes O No If yes, please explain:  Do you take, or have you taken, Priem-Fen or Redux? O Yes O No  Nor you on a special diet? O Yes O No  Do you use controlled substances? O Yes O No  Nor you on a special diet? O Yes O No  Do you take or have you had, any of the following?  O Applin O Penicillin O Codeline O Acrylic O Metal O Latex O Local Anesthetics  O Other please explain:  Do you have, or have you had, any of the following? (Please fill in the circles completely ie. ●)  Alzheimeris Disease O Yes O No Disablese O Yes O No Hemophila O Yes O No Renal Dislaysis O Yes O No Applyaxis O Yes O No Disablese O Yes O No Hemophila O Yes O No Renal Dislaysis O Yes O No Renal Dislaysis O Yes O No Disablese O Yes O No Disablese O Yes O No Hemophila O Yes O No Renal Dislaysis O Yes O No R	Patient Name:					_ Birth Da	ate:		_ Age:_	
Are you under a physician's care now? O Yes O No If yes, please explain:			FIRST							
lave you ever been hospitalized or had a major operation? O Yes O No If yes, please explain:  Have you ever had a serious head or neck injury? O Yes O No If yes, please explain:  Do you take, or have you taken, Phen-Fen or Redux? O Yes O No If yes, please explain:  Are you on a special diet? O Yes O No Do you use lobacco? O Yes O No Do you use lobacco? O Yes O No Women: Are you Pregnant / Trying to get pregnant? O Yes O No Taking oral contraceptives? O Yes O No Other please explain:  Do you have, or have you had, any of the following? O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Local Anesthetics  O Other please explain:  Do you have, or have you had, any of the following? (Please fill in the circles completely le. ◆) Albritime's Disease Visa No Contisone Medicine O Yes O No Hemophilis O Yes O No Renal Dialysis O Yes O No Albritime's Disease O Yes O No Drug Addiction O Yes O No Hempstatis A O Yes O No Renal Dialysis O Yes O No Ranghylavios O Yes O No Drug Addiction O Yes O No Hempstatis A O Yes O No Emptyymen O Yes O No Emptyymen O Yes O No Hempstatis O Yes O No Emptyymen O Yes O No Hempstatis O Yes O No Hempstatis O Yes O No Renal Dialysis O Yes O No Renal Dialysis O Yes O No Hempstatis O Yes O	r medication that									
Are you taking any medications, pills, or drugs? Q Yes O No I Yes O No Do you take, or have you taken, Phen-Fen or Redux? O Yes O No Do you use controlled substances? O Yes O No Western State of the Controlled Substances? O Yes O No Do you use controlled substances? O Yes O No		en hospitalized or ha	d a major operation? O	Yes O No If y	yes, please	explain:				
Are you on a special dier? O Yes O No Do you use controlled substances? O Yes O No Women: Are you Pregnant / Trying to get pregnant? O Yes O No Taking oral contraceptives? O Yes O No Nursing? O Yes O No Are you altergic to any of the following? O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Local Anesthetics O Other please explain:  Do you have, or have you had, any of the following? (Please fill in the circles completely ie. ●) AlDS/HIVY O Yes O No Cortisone Medicine O Yes O No Hemophilia O Yes O No Alzhchiemer's Disease O Yes O No Do you have, or have you had, any of the following? (Please fill in the circles completely ie. ●) AlDS/HIVY O Yes O No Cortisone Medicine O Yes O No Hemophilia O Yes O No Alzhchiemer's Disease O Yes O No Do you have, or have you had, any of the following? (Please fill in the circles completely ie. ●) Alzhchiemer's Disease O Yes O No Do you have, or have you had, any of the following? (Please fill in the circles completely ie. ●) Alzhchiemer's Disease O Yes O No Do you have, or have you had, any of the following? (Please fill in the circles completely ie. ●) Alzhchiemer's Disease O Yes O No Do you have, or have you had, any of the following? (Please fill in the circles completely ie. ●) Alzhchiemer's Disease O Yes O No Do you have, or have you had, any of the following? (Please fill in the circles completely ie. ●) Alzhchiemer's Disease O Yes O No Do you have, or have you had, any of the following? (Please fill in the circles completely ie. ●) Alzhchiemer's Disease O Yes O No Do you have, or have you had, any of the following? (Please fill in the circles completely ie. ●) Alzhchiemer's Disease O Yes O No Do you have, or have you had, any of the following? (Please fill in the circles completely ie. ●) Alzhchiemer's Disease O Yes O No Do you had you h	Are yo	ou taking any medica	ations, pills, or drugs? O	Yes O No If y	yes, please	explain:				
Program   Trying to get pregnant? O Yes O No   Taking oral contraceptives? O Yes O No   Nursing? O Yes O No	Do you take,	Are	ou on a special diet? O	Yes O No						
Are you allergic to any of the following?  O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Local Anesthetics  O Other please explain:  Do you have, or have you had, any of the following? (Please fill in the circles completely ie. ●)  AlDSHIV+ O Yes O No Cordisone Medicine O Yes O No Hemphilia O Yes O No Renal Dialysis O Yes O No Alzehimer's Disease O Yes O No Diag Addiction O Yes O No Hepatitis B or C O Yes O No Renal Dialysis O Yes O No Alzehimer's Disease O Yes O No Diag Addiction O Yes O No Hepatitis B or C O Yes O No Renal Dialysis O Yes O No Alzehimer's Disease O Yes O No Diag Addiction O Yes O No Hepatitis B or C O Yes O No Renal Dialysis O Yes O No Alzehimer's Disease O Yes O No Diag Addiction O Yes O No Hepatitis B or C O Yes O No Renal Dialysis O Yes O No Alzehimer's Disease O Yes O No Diag Addiction O Yes O No Hepatitis B or C O Yes O No Renal Dialysis O Yes O No Alzehimer's Disease O Yes O No Hepatitis B or C O Yes O No Renal Dialysis O Yes O No Hepatitis B or C O Yes O No Renal Dialysis O Yes O No Hepatitis B or C O Yes O No Renal Dialysis O Yes O No Hepatitis B or C O Yes O No Renal Dialysis O Yes O No Hepatitis B or C O Yes O No Renal Dialysis O Yes O No Hepatitis B or C O Yes O No Renal Dialysis O Yes O No Hepatitis B or C O Yes O No Renal Dialysis O Yes O No Hepatitis B O Yes O No H			•							
O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Local Anesthetics  O Other please explain:  Do you have, or have you had, any of the following? (Please fill in the circles completely ie. ●)  AIDS/HIV+ O Yes O No Cortisone Medicine O Yes O No Hemophilia O Yes O No Renal Dialysis O Yes O Alzheimer's Disease O Yes O No Diabetes O Yes O No Hepatitis A O Yes O No Renal Dialysis O Yes O No Alzheimer's Disease O Yes O No Diabetes O Yes O No Hepatitis A O Yes O No Renal Dialysis O Yes O No Alzheimer's Disease O Yes O No Diabetes O Yes O No Hepatitis B or O Yes O No Renal Dialysis O Yes O No Anaphylaxis O Yes O No Emphysema O Yes O No Hepatitis B or O Yes O No Scarlet Fever O Yes O Angina O Yes O No Emphysema O Yes O No Hepatitis B or O Yes O No Scarlet Fever O Yes O No Arthritios Heart Valve O Yes O No Emphysema O Yes O No Hepatitis B or O Yes O No Scarlet Fever O Yes O No Arthritios Heart Valve O Yes O No Emphysema O Yes O No Hepatitis B or O Yes O No Scarlet Fever O Yes O No Arthritios Heart Valve O Yes O No Emphysema O Yes O No Herpes O Yes O No Her	-		O Yes O No Taking ora	al contracepti	ives? O Yes	s O No	Nursing	g? O Yes O	No	
AIDS/HIV+ O Yes O No	O Aspirin O I	Penicillin O Code	eine O Acrylic O N	∕letal O La	atex O I	_ocal Anes	ethetics			
Alzheimer's Disease	Do you have, or h	have you had, any o	f the following? (Please fi	II in the circle	es complete	ly ie. ●)				
Anaphylaxis O Yes O No Drug Addiction O Yes O No Hepatitis B or C O Yes O No Rehumatism O Yes O Anemia O Yes O No Easily Wounded O Yes O No Herpes O Yes O No Scarle Fever O Yes O Angina O Yes O No Easily Wounded O Yes O No High Blood Pressure O Yes O No Scarle Fever O Yes O Angina O Yes O No Emphysema O Yes O No High Blood Pressure O Yes O No Sinus Trouble O Yes O Arthritis/Gout O Yes O No Excessive Prints O Yes O No High Blood Pressure O Yes O No Sinus Trouble O Yes O Arthritis Heart Valve O Yes O No Excessive Prints O Yes O No Hypoglycemia O Yes O No Sinus Trouble O Yes O Xo Arthritian Heart Valve O Yes O No Excessive Prints O Yes O No Introduce Heartbeat O Yes O No Sinus Trouble O Yes O Xo Asthma O Yes O No Frequent Diarritis O Yes O No Introduce Heartbeat O Yes O No Sinus Trouble O Yes O Xo Asthma O Yes O No Frequent Diarritis O Yes O No Introduce Heartbeat O Yes O No Sinus Trouble O Yes O Xo Asthma O Yes O No Frequent Diarritis O Yes O No Introduce O Yes O					•			-		O Yes O No
Anemia O Yes O No Easily Wounded O Yes O No Herpes O Yes O No Scarlet Fever O Yes C Angina O Yes O No Emphysema O Yes O No High Blood Pressure O Yes O No Shingles O Yes C Angina O Yes O No Emphysema O Yes O No High Blood Pressure O Yes O No Shingles O Yes C Artificial Heart Valve O Yes O No Excessive Bleeding O Yes O No Hives or Rash O Yes O No Sinus Trouble O Yes C Artificial Heart Valve O Yes O No Excessive Bleeding O Yes O No Hypoglycemia O Yes O No Sinus Trouble O Yes C Artificial Joint O Yes O No Excessive Bleeding O Yes O No Hypoglycemia O Yes O No Sinus Bifida O Yes C Artificial Joint O Yes O No Fanting Spells/Dizziness O Yes O No Kidney Problems O Yes O No Spina Bifida O Yes C No Shing Bifida O Yes C No Hypoglycemia O Yes O No Spina Bifida O Yes C No Shing Bifida O Yes C No Spina Bifida O Yes C No Hypoglycemia O Yes O No Spina Bifida O Yes C No Hypoglycemia O Yes O No Spina Bifida O Yes C No Hypoglycemia O Yes O No Spina Bifida O Yes C No Hypoglycemia O Yes O No Spina Bifida O Yes C No Hypoglycemia O Yes O No Spina Bifida O Yes C No Hypoglycemia O Yes O No Spina Bifida O Yes C No Hypoglycemia O Yes O No Spina Bifida O Yes C No Hypoglycemia O Yes O No Hypoglycemia O Yes O No Spina Bifida O Yes C No Hypoglycemia O Yes O No Hypoglycemia O Yes O No Leukemia O Yes O No Spina Bifida O Yes C No Hypoglycemia O Yes O No Hypoglycemia O Yes O No Leukemia O Yes O No Spina Bifida O Yes C No Bifida O Yes O No Hypoglycemia O Yes O No Leukemia O Yes O No Leukemia O Yes O No Spina Bifida O Yes C No Bifida O Yes O No Leukemia O Yes O No Hypoglycemia O Ye	Alzheimer's Disease	e O Yes O No	Diabetes	O Yes O No	Hepatitis A		O Yes O No	Rheumatic I	ever	O Yes O No
Angina O Yes O No Emphysema O Yes O No High Blood Pressure O Yes O No Shingles O Yes O Arthritis/Gout O Yes O No Epilepsy or Seizures O Yes O No Hives or Rash O Yes O No Sickle Cell Disease O Yes O Arthritis/Gout I Heart Valve O Yes O No Excessive Bleeding O Yes O No Hypoglycemia O Yes O No Sickle Cell Disease O Yes O Arthritis/Gout I Heart Valve O Yes O No Excessive Bleeding O Yes O No Hypoglycemia O Yes O No Spina Biflida O Yes O Asthma O Yes O No Excessive Thirist O Yes O No Irregular Heartbeat O Yes O No Spina Biflida O Yes O Asthma O Yes O No Fainting Spells/Dizziness O Yes O No Kidney Problems O Yes O No Stomach/Intestinal Disease O Yes O No Frequent Cough O Yes O No Leukemia O Yes O No Stomach/Intestinal Disease O Yes O No Greathing Problem O Yes O No Frequent Beadaches O Yes O No Leukemia O Yes O No Swelling of Limbs O Yes O Ratabis Easily O Yes O No Genital Herpes O Yes O No Lung Disease O Yes O No Thyroid Disease O Yes O Ro Cancer O Yes O No Galacoma O Yes O No Lung Disease O Yes O No Thyroid Disease O Yes O No Cheen Dain Jaw Joints O Yes O No Theoretical Disease O Yes O No Thyroid Disease O Yes O No Cheen Dain Jaw Joints O Yes O No Theoretical Disease O Yes O No Ves O No Parathryroid Disease O Yes O No Ves O No	Anaphylaxis	O Yes O No	Drug Addiction	O Yes O No	Hepatitis B	or C	O Yes O No	Rheumatisn	n	O Yes O No
Arthritis/Gout O Yes O No Epilepsy or Seizures O Yes O No Hives or Rash O Yes O No Sickle Cell Disease O Yes O Arthritis/Heart Valve O Yes O No Excessive Bleeding O Yes O No Hypoglycemia O Yes O No Sinus Trouble O Yes O String Introble O Yes O No Introduced O Yes	nemia	O Yes O No	Easily Wounded	O Yes O No	Herpes		O Yes O No	Scarlet Feve	er	O Yes O No
rtificial Heart Valve  O Yes O No  Excessive Bleeding  O Yes O No  Hypoglycemia  O Yes O No  Sinus Trouble  O Yes O Rotificial Joint  O Yes O No  Excessive Thirst  O Yes O No  Irregular Heartbeat  O Yes O No  Spina Biffida  O Yes O No  Irregular Heartbeat  O Yes O No  Stomach/Intestinal Disease  O Yes O No  Irregular Heartbeat  O Yes O No  Stomach/Intestinal Disease  O Yes O No  Irregular Hospital  O Yes O No  Irregular Heartbeat  O Yes O No  Irregular Hospital  O Yes O No  Irregular Hospital Disease  O Yes O No  Irregular Hospital Disease  O Yes O No  Itro  O Yes O No  Irregular Headaches  O Yes O No  Irregular Headach	ngina	O Yes O No	Emphysema	O Yes O No	High Blood	Pressure	O Yes O No	Shingles		O Yes O No
ritficial Joint O Yes O No Excessive Thirst O Yes O No Irregular Heartbeat O Yes O No Spina Bifida O Yes O Sthma O Yes O No Fainting Spells/Dizziness O Yes O No Kidney Problems O Yes O No Stomach/Intestinal Disease O Yes O No Iodod Disease O Yes O No Frequent Cough O Yes O No Leukemia O Yes O No Stomach O Yes O No Iodod Disease O Yes O No Frequent Diarrhea O Yes O No Leukemia O Yes O No Stomach O Yes O No Iodod Disease O Yes O No Frequent Diarrhea O Yes O No Leukemia O Yes O No Swelling of Limbs O Yes O No Intertity o Yes O No Frequent Headaches O Yes O No Liver Disease O Yes O No Swelling of Limbs O Yes O No Intertity o Yes O No Genital Herpes O Yes O No Low Blood Pressure O Yes O No Thyroid Disease O Yes O No Intertity o Yes O No Genital Herpes O Yes O No Mitral Valve Prolapse O Yes O No Tonsillitis O Yes O No Heart Stack/Failure O Yes O No Parathyroid Disease O Yes O No Tumors or Growths O Yes O No Personage O Yes O No Tumors or Growths O Yes O No Old Stoms/Fever Blisters O Yes O No Heart Attack/Failure O Yes O No Parathyroid Disease O Yes O No Ulcers O Yes O No Ongenital Heart Disorder O Yes O No Heart Pace Maker O Yes O No Recent Weight Loss O Yes O No Venereal Disease O Yes O No Ongenital Heart Disorder O Yes O No Heart Trouble/Disease O Yes O No Recent Weight Loss O Yes O No Venereal Disease O Yes O No Intertity of Disease O Yes O No Venereal Disease O Yes O No Ongenital Heart Disorder O Yes O No Heart Trouble/Disease O Yes O No Recent Weight Loss O Yes O No Venereal Disease O Yes O No Ongenital Heart Disorder O Yes O No Heart Trouble/Disease O Yes O No Recent Weight Loss O Yes O No Venereal Disease O Yes O No Ongenital Heart Disorder O Yes O No Ongen	rthritis/Gout	O Yes O No	Epilepsy or Seizures	O Yes O No	Hives or Ra	sh	O Yes O No	Sickle Cell [	Disease	O Yes O No
sthma	rtificial Heart Valve	e O Yes O No	Excessive Bleeding	O Yes O No	Hypoglycen	nia	O Yes O No	Sinus Troub	le	O Yes O No
Allood Disease	rtificial Joint	O Yes O No	Excessive Thirst	O Yes O No	Irregular He	artbeat	O Yes O No	Spina Bifida		O Yes O No
lood Transfusion O Yes O No Frequent Diarrhea O Yes O No Liver Disease O Yes O No Swelling of Limbs O Yes O Retathing Problem O Yes O No Frequent Headaches O Yes O No Low Blood Pressure O Yes O No Thyroid Disease O Yes O No Cruise Easily O Yes O No Gentral Herpes O Yes O No Lung Disease O Yes O No Thyroid Disease O Yes O No Cancer O Yes O No Glaucoma O Yes O No Lung Disease O Yes O No Tonsillitis O Yes O Render O Yes O No Hay Fever O Yes O No Pain in Jaw Joints O Yes O No Tumors or Growths O Yes O No Pain in Jaw Joints O Yes O No Tumors or Growths O Yes O No Pain in Jaw Joints O Yes O No Ulcers O Yes O No Parathyroid Disease O Yes O No Ulcers O Yes O No Organial Heart Disorder O Yes O No Heart Attack/Failure O Yes O No Paychiatric Care O Yes O No Venereal Disease O Yes O No Organial Heart Disorder O Yes O No Heart Trouble/Disease O Yes O No Recent Weight Loss O Yes O No Yellow Jaundice O Yes O No Pave Yellow Jaundice O Yes O No Yes	sthma	O Yes O No	- ·	O Yes O No		olems	O Yes O No	Stomach/Int	estinal Disease	O Yes O No
reathing Problem O Yes O No Frequent Headaches O Yes O No Low Blood Pressure O Yes O No Thyroid Disease O Yes O No ruise Easily O Yes O No Genital Herpes O Yes O No Lung Disease O Yes O No Tonsillitis O Yes O Stancer O Yes O No Glaucoma O Yes O No Mitral Valve Prolapse O Yes O No Tumors or Growths O Yes O No Heart Matack/Failure O Yes O No Pain in Jaw Joints O Yes O No Tumors or Growths O Yes O No Pain in Jaw Joints O Yes O No Tumors or Growths O Yes O No Pain in Jaw Joints O Yes O No Tumors or Growths O Yes O No Pain in Jaw Joints O Yes O No Tumors or Growths O Yes O No Indeed the Matack/Failure O Yes O No Parathyroid Disease O Yes O No Ulcers O Yes O No Pain In Jaw Joints O Yes O No Pain in Jaw Joints O Yes O No Tumors or Growths O Yes O No Indeed Indee										O Yes O No
ruise Easily O Yes O No Genital Herpes O Yes O No Lung Disease O Yes O No Tonsillitis O Yes O Rotancer O Yes O No Glaucoma O Yes O No Mitral Valve Prolapse O Yes O No Tuberculosis O Yes O Recent Prolapse O Yes O No Tuberculosis O Yes O Yes O No Pagn in Jaw Joints O Yes O No Tuberculosis O Yes O Yes O No Pagn in Jaw Joints O Yes O No Tuberculosis O Yes O No Pagn in Jaw Joints O Yes O No Tuberculosis O Yes O No Pagn in Jaw Joints O Yes O No Tuberculosis O Yes O No Pagn in Jaw Joints O Yes O No Ulcers O Yes O No Pagn in Jaw Joints O Yes O No Ulcers O Yes O No Pagn in Jaw Joints O Yes O No Ulcers O Yes O No Pagn in Jaw Joints O Yes O No Ulcers O Yes O No Pagn in Jaw Joints O Yes O No Ulcers O Yes O No Pagn in Jaw Joints O Yes O No Ulcers O Yes O No Pagn in Jaw Joints O Yes O No Ulcers O Yes O No Pagn in Jaw Joints O Yes O No Ulcers O Yes O No Ulcers O Yes O No Pagn in Jaw Joints O Yes O No Ulcers O Yes O No Pagn in Jaw Joints O Yes O No Ulcers O Yes O No Venereal Disease O Yes O No Pagn in Jaw Joints O Yes O No Venereal Disease O Yes O No Pagn in Jaw Joints O Yes O No Venereal Disease O Yes O No Pagn in Jaw Joints O Yes O No Venereal Disease O Yes O No Pagn in Jaw Joints O Yes O No Venereal Disease O Yes O No Pagn in Jaw Joints O Yes O No Venereal Disease O Yes O No Pagn in Jaw Joints O Yes O No Venereal Disease O Yes O No Pagn in Jaw Joints O Yes O No Venereal Disease O Yes O No Pagn in Jaw Joints O Yes O No Venereal Disease O Yes O No Pagn in Jaw Joints O Yes O No Venereal Disease O Yes O No Pagn in Jaw Joints O Yes O No Venereal Disease O Yes O No Pagn in Jaw Joints O Yes O No Venereal Disease O Yes O No Pagn in Jaw Joints O Yes O No Venereal Disease O Yes O No Pagn in Jaw Joints O Yes O No Venereal Disease O Yes O No Pagn in Jaw Joints O Yes O No Venereal Disease O Yes O No Pagn in Jaw Joints O Yes O No Venereal Disease O Yes O No Venereal Disease O Yes O No Pagn in Jaw Joints O Yes O No Venereal Disease O Yes O No Venereal Dise			·					_		O Yes O No
Annacer O Yes O No Glaucoma O Yes O No Mitral Valve Prolapse O Yes O No Tuberculosis O Yes O Remotherapy O Yes O No Hay Fever O Yes O No Pain in Jaw Joints O Yes O No Tumors or Growths O Yes O Remotherapy O Yes O No Heart Attack/Failure O Yes O No Parathyroid Disease O Yes O No Ulcers O Yes O Yes O No Parathyroid Disease O Yes O No Ulcers O Yes O Yes O No Parathyroid Disease O Yes O No Venereal Disease O Yes O No Pasychiatric Care O Yes O No Venereal Disease O Yes O No Pasychiatric Care O Yes O No Venereal Disease O Yes O No Pasychiatric Care O Yes O No Venereal Disease O Yes O No Pasychiatric Care O Yes O No Venereal Disease O Yes O No Pasychiatric Care O Yes O No Venereal Disease O Yes O No Pasychiatric Care O Yes O No Venereal Disease O Yes O No Pasychiatric Care O Yes O No Venereal Disease O Yes O No Pasychiatric Care O Yes O No Venereal Disease O Yes O No Pasychiatric Care O Yes O No Venereal Disease O Yes O No Pasychiatric Care O Yes O No Venereal Disease O Yes O No Pasychiatric Care O Yes O No Venereal Disease O Yes O No Pasychiatric Care O Yes O No Venereal Disease O Yes O No Pasychiatric Care O Yes O No Venereal Disease O Yes O No Pasychiatric Care O Yes O No Venereal Disease O			·					-	ease	O Yes O No
hemotherapy O Yes O No Hay Fever O Yes O No Pain in Jaw Joints O Yes O No Tumors or Growths O Yes O hest Pains O Yes O No Heart Attack/Failure O Yes O No Parathyroid Disease O Yes O No Ulcers O Yes O O Yes O No O Yes O No Parathyroid Disease O Yes O No Ulcers O Yes O O Yes O O Yes O No O Yes O Yes O No O Yes O Yes O Yes O No O Y	•		·		· ·					O Yes O No
hest Pains O Yes O No Heart Attack/Failure O Yes O No Parathyroid Disease O Yes O No Ulcers O Yes O No Old Sores/Fever Blisters O Yes O No Heart Murmur O Yes O No Psychiatric Care O Yes O No Venereal Disease O Yes O O Yes O No One Psychiatric Care O Yes O No Venereal Disease O Yes O O Yes O No One Psychiatric Care O Yes O No O Yes O Yes O No O Yes O Yes O No O Yes O Yes O Yes O No O Yes O						•				O Yes O No
the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication tify that I consent to the performing of x-rays and oral examination.  Date	. ,		•						Browths	O Yes O No
congenital Heart Disorder O Yes O No Heart Pace Maker O Yes O No Radiation Treatments O Yes O No Yellow Jaundice O Yes O No Incomplete of the Dest of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication tify that I consent to the performing of x-rays and oral examination.  Date					-					O Yes O No
Convulsions O Yes O No Heart Trouble/Disease O Yes O No Recent Weight Loss O Yes O No lave you ever had any serious illness not listed above? O Yes O No comments:  the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication tify that I consent to the performing of x-rays and oral examination.  Date  COT Signature Date  PDATE TO MEDICAL HISTORY					-					O Yes O No
the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication rtify that I consent to the performing of x-rays and oral examination.  Date  Date  PDATE TO MEDICAL HISTORY	Convulsions	O Yes O No	Heart Trouble/Disease	O Yes O No	Recent Wei	ght Loss		Yellow Jaur	idice	O Yes O No
the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication entify that I consent to the performing of x-rays and oral examination.  Date  Doctor Signature  PDATE TO MEDICAL HISTORY										
PDATE TO MEDICAL HISTORY  Date  Printip that I consent to the performing of x-rays and oral examination.  Date  Date  Date	Johnnello									
ertify that I consent to the performing of x-rays and oral examination.  Date  Doctor Signature  PDATE TO MEDICAL HISTORY										
Date PDATE TO MEDICAL HISTORY					urately. I will	inform my c	dentist of any c	hange in my	health and/or m	edication. I furth
PDATE TO MEDICAL HISTORY	itient signature or	parent if patient is a n	ninor						Date _	
	octor Signature								Date _	
ate   Comments   Patient Signature   Doctor Signature					Τ.	Datis t O'			Deets: C'	t
. a Social digitation	ate Com	iments				-attent Sig	nature		Doctor Signa	шге