SALT LAKE - DENTAL CLINIC -

WELLCOME



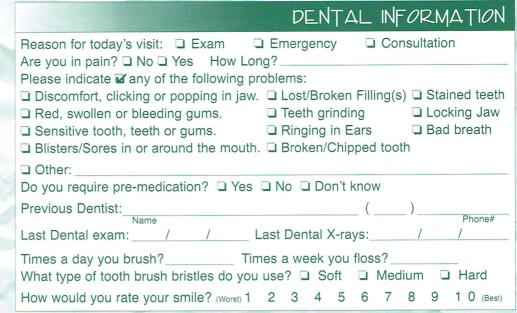
Today's Date:	1	/	F	ile #:	
Patient Name:					
LAST			FIRST		MI
What You Prefer To E	Be Called			_ □ Male □	Female
Birthdate:/	Ag	je:	SS#:_		
Mailing Address:					
OUTV		STA	TE.		ZIP
CITY	\	-			ZIF
Home Phone #: ()				
Work Phone #: ()			Ext:_	
Cell Phone #: ()				
E-mail Address:					
Referred By:					
Employer:			How	Long?	
Employer's Address:					
CITY		STA	ATE		ZIP
Occupation:					
Status: Minor Sing	le 🗆 Marrie	ed 🖵 Divo	rced 🗆 Sep	arated 🗆 W	/idowed
Spouse's Name:					
Do you have children	n? □Yes	□No	How ma	ny?	



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typo	INSURANCE INFO
Primary Dental Insur	rance
Co. Name:	
Address:	
CITY	STATE ZIP
Phone #: ()	
Insured's ID#:	
Group # (Plan, Local, c	or Policy #):
Insured's Name:	
Relation:	Date of Birth:/
Insured's Employer:	
Secondary Dental Ir	surance
Co. Name:	
Address:	
CITY	STATE ZIP
Phone #: ()	
Insured's ID#:	
Group # (Plan, Local, o	or Policy #):
Insured's Name:	
Relation:	Date of Birth://
Insured's Employer:	

	f Alice
1	IN EVENT OF EMERGENCY
-	Whom should we contact?
	Relation:
	Home Phone #: ()
	Work Phone #: ()
	Cell Phone #: ()
	Who is your Medical Doctor?
	Medical Doctor's Phone #: ()

five
LAKE CLINIC -



MEDICAL HISTORY
What medications are you taking? ☐ Nerve pills ☐ Pain killers (including aspirin) ☐ Muscle relaxers ☐ Stimulants ☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Meds for Osteoporosis ☐ Other(s), please list:
Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) Yes No Phen-fen/Redux Yes No No Poyou have or have you had any of the following diseases, medical conditions or procedures? Y N Heart Attack / Stroke Y N Thyroid Problems Y N Cancer/Tumors Y N Cosmetic Surgery Y N Heart Surg./Pacemaker Y N Kidney Problems Y N Shingles Y N Xray or Cobalt Treatment Y N Heart Murmur Y N Respiratory Problems Y N Hepatitis Y N Chemotherapy Y N Rheumatic Fever Y N Respiratory Problems Y N HIV+/AIDS/ARC Y N Asthma Y N Mitral Valve Prolapse Y N Sinus Problems Y N Artificial Bones/Joints Y N Difficulty Breathing Y N Artificial Valves Y N Psychiatric Problems Y N Emphysema Y N Leukemia Y N Congenital Heart Defect Y N Venereal Disease Y N Fainting/Seizures/Epilepsy Y N Anemia Y N Chest Pains Y N Alcohol/Drug Abuse Y N Severe/Frequent Headaches Y N High/Low Blood Pressure Y N Scarlet Fever Y N Jaw Problems TMJ/TMD Y N Back Problems Y N Glaucoma
Please list any other surgeries or medical conditions you have or ever had:
Are you allergic to any of the following? Latex Penicillin / Amoxicillin Tetracycline Aspirin Dental Anesthetics Foods: Others:
Do you use tobacco? ☐ No ☐ Yes/How used? How much? How long?
Please rate your general health from 1-10: Do you wear contact lenses? □ Yes □ No For women: Are you taking Birth Control pills? □ Yes □ No How many children have you had? Are you Pregnant? □ No □ Yes/How long? Are you nursing? □ Yes □ No

Are you Pregnant? No Yes/How long? Are you nursing? Yes No	au:
♦ We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.	UPDATE (OFFICE USE)
Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.	Initials Date Comments
♦ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.	Initials / / / Date
I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided. I acknowledge that I have received a copy of the Summary of Privacy Notice.	Comments / / Initials Date
Initials Signature Date/	Comments