Fit For Life 🔲 🛛 Eat 🛴	althy 🗉 Sch	edule Regular(), xams	Be Fit For Life
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## Thank You for Selecting Our Dental Team

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

## Patient Information (Confidential)

12221112220000000000000000000000000000	
Patient	
Number	

**Be Fit For Lif** 

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Name		Date
SS#/SIN	Birthdate	
Address	City	State/ Zip/ Prov P.C
Email		Cell Phone
Check Appropriate Box: Minor Sin	gle Married Separated	
If Student, Name of School/College	City	State/ Prov Full Time Part Time
Patient or Parent/Guardian's Employer		Work Phone
Business Address	City	State/ Zip/ Prov. P.C.
Spouse or Parent/Guardian's Name	Employer	Work Phone
Whom May We Thank for Referring You?		
Person to Contact in Case of Emergency		Phone
Responsible Party		
0		Relationship to Patient
Address		
	Birthdate	Financial Institution
		SS#/SIN
Is this Person Currently a Patient in our Office?		
For your convenience, we affer the following method		an profer Propagat in full at each appointment
Insurance Informatio		<ul> <li>I wish to discuss the office's payment policy.</li> <li>Relationship</li> </ul>
Name of Insured		to Patient
Name of Employer		State/ Zin/
Employer Address		
Insurance Company	Group #	Stare/ Zip/
Ins. Co. Address	City	Prox 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 Follow	
Name of Insured		Relationship to Patient
BirthdateSS#/SIN		Date Employed
Name of Employer	Union or Local #	
	111 Mar 134 113 12 341 134 14	
Employer Address		State/ Zip/ PESN. P.C.
	City	Prov. P.C Policy/ID#
Insurance Company	City Group #	Prov. P.C Policy/ID# State/ Zip/
Insurance Company	City Group # City	Prov. P.C Policy/ID# State/ Zip/ Prov. P.C

Be Fit For Life

## Patient Medical History

1. Are you under medical tensment now?       Io. Are you wearing contact lenses?       Io. Are you wearing contact lenses?       Io. Are you allengic to or have you had any reactions to the following?         1. Are you unking any medication(s) including       Io. Are you allengic to or have you had any reactions to the following?       Io. Are you wearing contact lenses?       Io. Brain and the last 5 years?         3. Are you unking any medication(s) including       Io. Are you taking any medication(s) including       Io. Brain and the last 5 years?       Io. Brain and the last 5 years?         4. Have you ever taken For Meddux?       Io. Are you taking any medication(s) are you taking?       Io. Brain and the last 6 g. mickel, mercury; etc.?         4. Have you ever taken For Meddux?       Io. Are you mercane the Wages. Revalue. Calls or Levitra in the last 24 hours?       Io. No weak a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?         7. Do you use controlled subsances?       Io. No weak and increations on think you may be pregnant?       Io. Are you marsing?         9. Do you use controlled subsances?       Yes No       Kes No         Hard Attack       Cardiac Pacemaker       Easily Winded       Io. Stroke         Breining/Scitures       Frequently Tired       Taber you taking on anomal contraceptives?       Io. Key No         No you use controlled subsances?       Io. Anomal       Io. Breat/Allengies       Io. Are you marsing?         <	Physician			0		Office Phone			Date of Last Exam		
	,										No
2. How you very team base within the lists '9 years'	1. Are you under medical treatment	now?					10 Are you w	earing co	ontact lenses?		
opperation of steppedium	surfaces and a contraction of a model of a second second		irgical			1944				ing?	
If yre, place explain       Prescultin or any other Authonics         3. Are yrea using are medication(s) including       Salib Progs         in yrea what medication(s) are you taking?       Prescultin or any other Authonics         if yrea, what medication(s) are you taking?       Prescultin or any other Authonics         if yrea, what medication(s) are you taking?       Prescultin or any other Authonics         if yrea, what medication(s) are you taking?       Prescultin or any other a persistent cough or throst clearing not         if have you over taken from Presculting Stopbophonates?       Prescultin or think you may be pregnant?         if have you over taken from Presculting?       Presculting out a haver athones?         if have you over taken from Presculting?       Presculting out a haver athones?         if have you have three you halor any of the following?       Presculting out any of the following?         8. Do you have ot have you have at the following?       Yes. No         High Biodof Pressure       Herri Murmant         Biodof Pressure       Herri Murmant         Prescultify Tried       Prescultify Tried         Authin       Arterial Prescultify Tried         Authin       Arterial Prescultify Tried         State Prescultify Tried       Prescultify Tried         Authin       Arterial Prescultify Tried         Authin       Prescultify T	operation or serious illness withi	n the last	5 years?							ing.	
3. Are year lating any medication(s) including	If yes, please explain						Penicillin Sulfa Drug	or any of			
Arry Metals (e.g. nickel, mercury, etc.)         Arry Metals (e.g. nickel, mercury, etc.)         Betwe you ever taken Fen-Phen/Redux?         Betwe you are Nage. Results, Calls or Levitz         in the last 24 hours?         Do you take or have you have a persistent cough or throst clearing not associated with a known illuss? (losing more than 3 weeks)?         Betwe wou known?         Betwe wou known?         Bo you take or have you have an have you had any of the following?         We in Area taken Ferein         High Blood Pressure         Berning/Scientres         Andrains         Parantize         Prequently Tried         Andrains         Parantize         District Prequently Tried         Andrains         Andrains         Preprinto/Pholens         District Preprinto/Pholens         District Preprinto/Pholens         District Preprinto/Pholens         District Preprinto/Pholens         Distre or laws down and cost pa	<ol> <li>Are you taking any medication(s non-prescription medicine?</li> </ol>	) includin	g				Sedatives	5		B	
	If yes, what medication(s) are yo	u taking?					Any Metal	s (e.g. ni	ickel, mercury, etc.)	Ξ	
ancer medications containing hisphosphonate?	4. Have you ever taken Fen-Phen/R	edux?						ber		H	H
6. Have you faken Vigga, Revatio, Calils or Levitra in the last 24 hours?  7. Do you use robisecs?  7. Do you use robisecs?  8. Do you use robisecs?  8. Do you use robisecs?  8. Do you use controlled substances?  8. Do you controlled substances?  8. Do you use controlled substances?  8. Do you is controlled substances?  9. Do you deven you reten?  9. Do you is controlled substances?  9. Do y											
7. Do you use related?		Cialis or I	evitra				13. Women Or	aly:			
8. Do you use controlled substances?	7. Do you use tobacco?						and the second se		or think you may be pregnant?	H	
No       No       Yes       No       No         High Blood Pressure       Heart Atuach       Cardiac Pacemaker       Easily Winded       Image: Cardiac Pacemaker         Riceuratic Forer       Heart Murmur       Stroke       Image: Cardiac Pacemaker       Image: Cardiac Pacemaker <td< td=""><td>8. Do you use controlled substances</td><td>57</td><td></td><td></td><td></td><td></td><td></td><td></td><td>1 contraceptives?</td><td></td><td></td></td<>	8. Do you use controlled substances	57							1 contraceptives?		
High Blood Pressure       Heart Disease       Chest Pains       Image: Chest Pains         Heart Attack       Grafiac Pacemaker       Easily Winded         Swollen Ankles       Angina       Heart Murmut         Statuman       Angina       Hay Forez(Allergies         Jatuation Therapy       Image: Chest Pains       Image: Chest Pains         Low Blood Pressure       Emphysema       Image: Chest Pains       Image: Chest Pains         Low Blood Pressure       Emphysema       Image: Chest Pains       Image: Chest Pains         Low Blood Pressure       Englistic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listic/Listi/Listic/Listic/Listic/Listic/Listic/Listic/Listic/List	9. Do you have or have you had an	y of the fo	llowing?				The Address of	11126-0111			
Harr Attack       Cardiac Pacemaker       Easily Winded         Raeumate Fever       Heart Murmur       Easily Winded         Raeumate Fever       Heart Murmur       Hay Fever/Allergies         Painting/Settures       Frequently Tired       Hay Fever/Allergies         Andma       Badiation Therapy       Importance         Low Bood Pressure       Employsema       Glaucoma         Epileps/Convulsions       Cancer       Recent Weight Loss         Low Bood Pressure       Joint Replacement of Implant       Heart Trouble         Diabetes       Joint Replacement of Implant       Heart Trouble         Prestores Dentist       Sexually Transmitted Disease       Mitral Valve Prelapse         Physical Problem       Stomach Troubles/Ulcers       Other         Prestores Dentists Location       Po you with your they or thesh frequent headaches?       No         1. Do your gums bleed while beashing or Bossing?       8. Do you with your they or thesh frequent headaches?       Date of Last Exam <td></td> <td></td> <td>1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1</td> <td></td> <td></td> <td></td> <td>Yes</td> <td>No</td> <td></td> <td>Yes</td> <td>No</td>			1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1				Yes	No		Yes	No
Rheumatic Fover       Heart Murmar       Stroke       Imagina         Swollen Ankles       Angina       Imagina       Stroke       Imagina         Swollen Ankles       Angina       Imagina       Requently Tired       Imberculosis         Asthma       Anemia       Requently Tired       Imberculosis       Implysema         Epilepsy/Convulsions       Cancer       Recent Weight Loss       Implysema         Epilepsy/Convulsions       Cancer       Recent Weight Loss       Implysema         Dibetes       Joint Replacement or Implant       Hear Touble       Implysema         Dibetes       Joint Replacement or Implant       Hear Touble       Implysema         AlDS or HIV Infection       Sexually Transmitted Disease       Mitral Valve Prolapse       Implysema         Previous Dentist	High Blood Pressure			Heart Di	sease				Chest Pains		
Swolen Ankles       Angina       Hay Fever/Allergies         Fainting/Scitures       Frequently Tired       Tuberculosis         Andemia       Radiation Therapy.         Low Bood Pressure       Emphysema       Glaucoma         Low Bood Pressure       Emphysema       Glaucoma         Low Bood Pressure       Emphysema       Glaucoma         Low Bood Pressure       Imphysema       Glaucoma         Low Bood Pressure       Joint Replacement or Implant.       Heart Trouble         Diabetes       Joint Replacement or Implant.       Heart Trouble         Name of Previous Dentist       Scauly Transmitted Disease       Miral Valve Problems         Previous Dentist       Scauly Transmitted Disease       Other         Previous Dentist       Date of Last Exam       Previous Dentist         Previous Dentist       Previous Dentist       Date of Last Exam         Previous Dentist       Previous Dentist       Previous Dentist         2. Are your tech sensitive to sweet or sour Biguids/foods?       Do you Tips or file/sols foogenity?         3. Do you raye guas Meed while brashing or Rossing?       B. Do you Cench or gring or Quar tech?         3. Are your tech sensitive to sweet or sour Biguids/ofoods?       Do you anay frequent headaches?         4. Do yous and red any bread, neck or jaw tiguids/fo	Heart Attack			Cardiac	Pacem	aker			Easily Winded		
Faining/Scitures       Frequently Tired       Display         Asthma       Anemia       Radiation Therapy         Low Bood Pressure       Emphysema       Glaucoma         Epilepsy/Convulsions       Cancer       Recent Weight Loss         Diabetes       Joint Replacement or Implant       Heart Trouble         Name of Previous Dentist       Hepatitis/Jaundice       Respiratory Problems         ALDS or HIV Infection       Sexually Transmitted Disease       Other         Previous Dentist       Calcent       Date of Last Exam         Auto or Previous Dentist       Previous Dentist Location       Date of Last Exam         1. Do your gums bleed while benashing or Bossing?       No       8. Do you have frequent headaches?       Date of Last Exam         2. Are your teeth sensitive to but or cold Inguids/foods?       9. Do you cench or grind your teeth?       Date of Last Exam         3. Are your teeth sensitive to sever or sour beguids/foods?       10. Do you bite your have frequent headaches?       No         4. How you had any head, neck or jax injuries?       12. Have you ever read any difficult extractions in the past?       13. Have you had any head, neck or jax injuries?       14. How you ward entities or partials?       How you law endities or opartials?       How you ward entities or partials?       How you ward entities or partials?       How you ward entities or partials?       How	Rheumatic Fever			Heart M	urmur				Stroke		
Faining/Scitures       Frequently Tired       Display         Asthma       Anemia       Radiation Therapy         Low Bood Pressure       Emphysema       Glaucoma         Epilepsy/Convulsions       Cancer       Recent Weight Loss         Diabetes       Joint Replacement or Implant       Heart Trouble         Name of Previous Dentist       Hepatitis/Jaundice       Respiratory Problems         ALDS or HIV Infection       Sexually Transmitted Disease       Other         Previous Dentist       Calcent       Date of Last Exam         Auto or Previous Dentist       Previous Dentist Location       Date of Last Exam         1. Do your gums bleed while benashing or Bossing?       No       8. Do you have frequent headaches?       Date of Last Exam         2. Are your teeth sensitive to but or cold Inguids/foods?       9. Do you cench or grind your teeth?       Date of Last Exam         3. Are your teeth sensitive to sever or sour beguids/foods?       10. Do you bite your have frequent headaches?       No         4. How you had any head, neck or jax injuries?       12. Have you ever read any difficult extractions in the past?       13. Have you had any head, neck or jax injuries?       14. How you ward entities or partials?       How you law endities or opartials?       How you ward entities or partials?       How you ward entities or partials?       How you ward entities or partials?       How	Swollen Ankles			Angina					Hay Fever/Allergies		
Dubetes       joint Replacement or Implant       Heart Trouble         Kidney Diseases       joint Replacement or Implant       Heart Trouble         Rispiratory Problems       Sexually Transmitted Disease       Mitral Valve Prolapse         AIDS or HIV Infection       Sexually Transmitted Disease       Mitral Valve Prolapse         Patient Dental History       Sumach Troubles/Ulcers       Other         Patient Dental History       Date of Last Exam	Fainting/Scizures			Frequen	tly Tire	ed					
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Dubetes       joint Replacement or Implant       Heart Trouble         Kidney Diseases       joint Replacement or Implant       Heart Trouble         Rispiratory Problems       Sexually Transmitted Disease       Mitral Valve Prolapse         AIDS or HIV Infection       Sexually Transmitted Disease       Mitral Valve Prolapse         Patient Dental History       Sumach Troubles/Ulcers       Other         Patient Dental History       Date of Last Exam			1					E I			E
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Thyroid Problem       Sumach Troubles/Ulcers       Other       Image: Chicking in the construction in the co	Contraction of the second s			1.00							-
Name of Previous Dentist									<ul> <li>A state of the sta</li></ul>	1	
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Name of Previous Dentist	Patient Denta	l Hi	story	ł							
Ves       No       Yes       No         1. Do your gums bleed while brushing or flossing?       B. Do you have frequent headaches?       B. Do you have frequent headaches?       B. Do you clench or grind your teeth?         2. Are your teeth sensitive to not or cold liquids/foods?       Do you clench or grind your teeth?       B. Do you bite your lips or checks frequently?       B. Do you bite your lips or checks frequently?         3. Are you have any sores or lumps in or near your mouth?       II. Have you ever had any prolonged bleeding       B. Do you was frequent headaches?         5. Do you have any sores or lumps in or near your mouth?       II. Have you ever had any prolonged bleeding       B. Do you was frequently?         6. Have you had any head, neck or jaw injuries?       II. Have you had any orthodontic treatment?       B. Do you wear dentures or partials?         7. Have you ever experienced any of the following       II. Have you wear dentures or partials?       II. Have you wear dentures or partials?         9 problems in your jaw?       If yes, date of placement       If yes, date of placement         9 Difficulty in opening or closing       If yes, date of vour teeth and gums?       If yes, date of placement         9 problems       If S. Do you like your smile?       If yes, date of placement       If yes, date of placement         9 Difficulty in chewing       If Yes, date of placement       If yes, date of placement       If yes, date of placement	Name of Previous Dentist			·					Date of Last Exam		-
1. Do your gums bleed while brushing or flossing?       8. Do you have frequent headaches?         2. Are your teeth sensitive to hot or cold inquids/foods?       9. Do you clench or grind your teeth?         3. Are your teeth sensitive to sweet or sour liquids/foods?       9. Do you bite your lips or cheeks frequently?         4. Do you have any sores or lumps in or near your mouth?       11. Have you ever had any difficult extractions in the past?         5. Do you have any sores or lumps in or near your mouth?       12. Have you ever had any prolonged bleeding         6. Have you had any head, neck or jaw injuries?       13. Have you were thad any orthodontic treatment?         7. Have you ever experienced any of the following       13. Have you wear dentures or partials?         problems in your jaw?       14. Do you wear dentures or partials?         Difficulty in spening or closing       15. Have you ever received oral hygiene instructions         Difficulty in chewing       16. Do you like your smile?         Authorization and Release       14. Do you wear dentures or partials?         I certify that 1 have read and understand the above information to the best of my knowledge. The above questions have been accurately ansowend. I understand that to reclease any information including the diagnosis and the records of any treatment or all services. I agree to be responsible for payment of all services mediered or my behall or my dependents.         Aurthorize and or near while the metrid and request my insurance       X	Previous Dentist's Location								Date of Last Cleaning		
1. Do your gums bleed while brushing or flossing?       8. Do you have frequent headaches?         2. Are your teeth sensitive to hot or cold inquids/foods?       9. Do you clench or grind your teeth?         3. Are your teeth sensitive to sweet or sour liquids/foods?       9. Do you bite your lips or cheeks frequently?         4. Do you have any sores or lumps in or near your mouth?       11. Have you ever had any difficult extractions in the past?         5. Do you have any sores or lumps in or near your mouth?       12. Have you ever had any prolonged bleeding         6. Have you had any head, neck or jaw injuries?       13. Have you were thad any orthodontic treatment?         7. Have you ever experienced any of the following       13. Have you wear dentures or partials?         problems in your jaw?       14. Do you wear dentures or partials?         Difficulty in spening or closing       15. Have you ever received oral hygiene instructions         Difficulty in chewing       16. Do you like your smile?         Authorization and Release       14. Do you wear dentures or partials?         I certify that 1 have read and understand the above information to the best of my knowledge. The above questions have been accurately ansowend. I understand that to reclease any information including the diagnosis and the records of any treatment or all services. I agree to be responsible for payment of all services mediered or my behall or my dependents.         Aurthorize and or near while the metrid and request my insurance       X					Yes	No				Yes	No
2. Are your teeth sensitive to hot or cold hquids/foods?       9. Do you clench or grind your teeth?         3. Are your teeth sensitive to sweet or sour liquids/foods?       9. Do you bite your lips or checks frequently?         4. Do you have any sores or lumps in or near your mouth?       11. Have you ever had any difficult extractions in the past?         5. Do you have any sores or lumps in or near your mouth?       12. Have you ever had any prolonged bleeding         6. Have you have any sores or lumps in or near your mouth?       13. Have you ever had any orthodontic treatment?         7. Have you ever experienced any of the following       13. Have you wear dentures or partials?         problems in your jaw?       14. Do you wear dentures or partials?         Clicking       15. Have you ever received oral hygiene instructions         print (joint, ear, side of face)       15. Have you ever received oral hygiene instructions         Difficulty in opening or closing       16. Do you like your smile?         Difficulty in chewing       16. Do you like your smile?         Authorization and Release       10. Morestand that providing incorrect information including the diagnosis and the treoords of any treatment or earning the case of your teeth and group insurance benefits otherwise payable to me 1 understand that my dental insurance carrier may pay less than the actuar bill for services. I agree to be responsible for payment of all services rendered co my behall or my dependents.         X	1. Do your gums bleed while brush	ing or flos	ssime?				8 Do you ha	ve freque	ent headaches?	1	0
5. Do you have any sores or humps in or near your mouth?       II. Have you ever had any prolonged bleeding         6. Have you had any head, neck or jaw injuries?       III. Have you ever had any prolonged bleeding         7. Have you ever experienced any of the following       III. Have you had any orthodontic treatment?         problems in your jaw?       III. Have you wear dentures or partials?         Clicking       If yes, date of placement         Pain (joint, ear, side of face)       III. Have you ever received oral hygiene instructions         Difficulty in opening or closing       IIII. Have you like your smile?         Authorization and Release       Inderstand that providing incorrect information can be dangerous to my health I authorize the dentist to celease any information including the diagnosis and the records of any treatment or payable to me. I understand that my dental insurance carrier may pay less tham the actual bill for services. I agree to be responsible for payment of all services rendered cut my behalf or my dependents.         X	Particular in the second se						100 C 10			1.1	101
5. Do you have any sores or humps in or near your mouth?       II. Have you ever had any prolonged bleeding         6. Have you had any head, neck or jaw injuries?       III. Have you ever had any prolonged bleeding         7. Have you ever experienced any of the following       III. Have you had any orthodontic treatment?         problems in your jaw?       III. Have you wear dentures or partials?         Clicking       If yes, date of placement         Pain (joint, ear, side of face)       III. Have you ever received oral hygiene instructions         Difficulty in opening or closing       IIII. Have you like your smile?         Authorization and Release       Inderstand that providing incorrect information can be dangerous to my health I authorize the dentist to celease any information including the diagnosis and the records of any treatment or payable to me. I understand that my dental insurance carrier may pay less tham the actual bill for services. I agree to be responsible for payment of all services rendered cut my behalf or my dependents.         X				2	E	1				-	111
5. Do you have any sores or humps in or near your mouth?       II. Have you ever had any prolonged bleeding         6. Have you had any head, neck or jaw injuries?       III. Have you ever had any prolonged bleeding         7. Have you ever experienced any of the following       III. Have you had any orthodontic treatment?         problems in your jaw?       III. Have you wear dentures or partials?         Clicking       If yes, date of placement         Pain (joint, ear, side of face)       III. Have you ever received oral hygiene instructions         Difficulty in opening or closing       IIII. Have you like your smile?         Authorization and Release       Inderstand that providing incorrect information can be dangerous to my health I authorize the dentist to celease any information including the diagnosis and the records of any treatment or payable to me. I understand that my dental insurance carrier may pay less tham the actual bill for services. I agree to be responsible for payment of all services rendered cut my behalf or my dependents.         X			quiusrionus	(I).	H	1				1	苦
6. Have you had any head, neck or jax injuries?       Image: following extractions?       Image: following extractions?         7. Have you ever experienced any of the following problems in your jaw?       Image: following extractions?       Image: following extractions?         7. Have you ever experienced any of the following problems in your jaw?       Image: following extractions?       Image: following extractions?         9. Chicking Pain (joint, ear, side of face)       Image: following extractions?       Image: following extractions?         9. Difficulty in opening or closing Difficulty in chewing       Image: following extractions       Image: following extractions         Authorization and Release       Image: following extraction formation can be dangerous to my health. I authorize the demitted 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 payers and/or health practitioners. I authorize and request my insurance       comparise to pay directly to the dentist or dental group insurance benefits of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance       comparise to pay directly to the dentist.         X       Image: following extractions?       following extractions?				1.7	H					- bia	1
7. Have you ever experienced any of the following       13. Have you had any orthodontic treatment?         problems in your jaw?       14. Do you wear dentures or partials?         Clicking       14. Do you wear dentures or partials?         Pain (joint, ear, side of face)       15. Have you ever received oral hygiene instructions         Difficulty in opening or closing       16. Do you like your smile?         Difficulty in chewing       16. Do you like your smile?         Authorization and Release       16. Do you like your smile?         Authorization and Release       19. Do you like your smile?         Company to pay directly to the dentist or dental group insurance benefits otherwise payable to me 1 understand that my dental insurance carrier may pay less than the actual for my dependents.         Pain information including the diagnoss 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 practitioanes. I authorize and request my insurance			-	né	H		-			100	170
problems in your jaw?       14. Do you wear dentures or partials?         Chcking       15. Have you ever received oral hygiene instructions         Difficulty in opening or closing       15. Have you ever received oral hygiene instructions         Difficulty in chewing       16. Do you like your smile?         Authorization and Release       16. Do you like your smile?         I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. 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 Demtal care to third party payers and/or health practitionaers. I authorize and request my insurance       compare to the responsible for payment of all services mendered on my insurance											
Clicking       If yes, date of placement         Pain (joint, ear, side of face)       If yes, date of placement         Difficulty in opening or closing       If yes, date of placement         Difficulty in opening or closing       If yes, date of placement         Difficulty in chewing       If yes, date of placement         Authorization and Release       If yes, date of placement         I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. 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 payers and/or health practitionaers. I authorize and request my insurance       compares to the responsible for payment of all services mendered on my child during the period of such Dental care to third		t the follo	א מכבאא א				the second se			77.0	
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