PATIENT INFORM	[ATIO]	N							
NAME									
Last			First !	Middle		"Nickname"			
ADDRESS			CITY	CITY		STATE	ZIP_		
TELEPHONE			(home) (wo			rk) (ce			(cell)
PREFERRED PHONE #				HT:		WT:	SE	X: N	1 F
DATE OF BIRTH: _			MARITAL STATUS:	S/M	/ W / D	O SSN:			
EMPLOYER			OCCUPATION						
BUSINESS ADDRES	SS					PHONE			
EMERGENCY CONTACT		RELATIONSHIP			PHONE				
PHYSICIAN			ADDRESS_						
DENTAL HISTORY	7								
CURRENT DENTIST	Γ			CITY			_STATE_		
Date of last dental visit			Date of last dental x-rays						
Reason for Today's V	isit:								
Have you ever had an	у сотр	licatio	ns following dental treatment?	YES N	1O				
If so, please explain:									
Please Circle: BAD BREATH BLEEDING GUMS CLICKING/POP JAW DRY MOUTH SWOLLEN GUMS LIP/CHEEK BITING	YES YES YES YES YES YES	NO NO NO NO NO	BITE CHANGES RECEDING GUMS GUM TREATMENT MOUTH PAIN, BRUSHING ORTHODONTIC TREATMEN SMOKING	YES YES YES YES TT YES YES	NO NO NO NO NO	SENSITIVITY T SENSITIVITY T LOOSE TEETH TENDER GUMS CLENCHING/G SPACE CHANG	O HEAT S RINDING	YES YES YES YES YES YES	NO NO NO NO NO
How often do you brush?			How often do you floss?						

MEDICAL HISTORY								
Please circle if you have be	oon troo	ted or	are under treatment for any	of the f	allowing	·•		
AIDS/HIV	YES	NO	FAINTING	YES	NO NO	RESPIRATORY PROBLEMS	YES	NO
ANEMIA	YES	NO	GLAUCOMA	YES	NO	RHEUMATIC FEVER	YES	NO
ARTHRITIS	YES	NO	HEAD INJURIES	YES	NO	SEIZURE DISORDER	YES	NO
ARTIFICAL JOINTS	YES	NO	JAUNDICE	YES	NO	SINUS PROBLEMS	YES	NO
ASTHMA	YES	NO	KIDNEY DISEASE	YES	NO	STOMACH PROBLEMS	YES	NO
BLEEDING DISORDER	YES	NO	LIVER DISEASE	YES	NO	STROKE	YES	NO
CANCER	YES	NO	LUNG DISEASE	YES	NO	SUBSTANCE ABUSE	YES	NO
DIABETES	YES	NO	NERVOUS DISORDER	YES	NO	TUBERCULOSIS	YES	NO
DIZZINESS	YES	NO	PACEMAKER	YES	NO	ULCERS	YES	NO
OTHER:								
Do you smoke or use tob If yes, how much? WOMEN: Are you preg MEDICATIONS: (Pleaseparate list.)	I nant?	oacks _l YES	per day NO Are you nursing?			ntly taking and dosages or provi	ide us v	vith a
ALLERGIES:								
Please do not write below this line – for office use only:								

NAME:

NCIAL INFORMATION		
unt - Please Circle Self / Guardian	/ Spouse / Father / Mother	
URANCE (unless on card)		
First Name:	DOB:	
Address:	City:	
	Employer	
	Employer.	
First Name: Address: Zip:	DOB: City: Employer:	
ly to the offices of Dr. Arthur H. Gager. I r will submit to dental insurance on my beent is due at the time of treatment unless dedications and perform such diagnostic, I grant the right to the dentist to release the	chalf and that payment of any remaining baland other arrangements have been made. I hereby a solotographic and therapeutic procedures as ma be information on this page and the dental/medi	ce is my authorize the ay be
	NCIAL INFORMATION unt - Please Circle Self / Guardian URANCE (unless on card) First Name: Address: Zip: Group #: INSURANCE (unless on card) First Name: Address: Zip: Group #:	NCIAL INFORMATION unt - Please Circle Self / Guardian / Spouse / Father / Mother URANCE (unless on card) First Name: DOB: City: Zip: Employer: Employer: Group #: INSURANCE (unless on card) First Name: DOB: City: Zip: Employer: Employer: