

IF THERE IS INSURANCE COVERAGE, PLEASE BRING THE NECESSARY FORMS TO THE CONSULTATION APPOINTMENT. SINCE IT IS THE POLICY OF THIS OFFICE TO BILL AND RECEIVE FULL PAYMENT DIRECTLY FROM OUR PATIENTS, WE REQUEST THAT YOU MAKE PAYMENTS FROM YOUR INSURANCE COMPANY PAYABLE TO YOU.

MEDICAL HISTORY

PHYSICIAN'S NAME.....

CURRENTLY UNDER A PHYSICIANS CARE?.....	.....Yes	.....No
CURRENTLY TAKING MEDICATION?.....	.....Yes	.....No
CURRENTLY UNDER PSYCHOLOGICAL GUIDANCE? .....	.....Yes	.....No
SEVERE ILLNESSES?.....	.....Yes	.....No
OPERATIONS?.....	.....Yes	.....No
BLEEDING DISORDERS?.....	.....Yes	.....No
ALLERGIES?.....	.....Yes	.....No
BIRTH DEFECTS?.....YesNo
TONSILS AND/OR ADENOIDS REMOVED?.....YesNo

PLEASE EXPLAIN ALL "YES" ANSWERS.....

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DENTAL HISTORY

DENTIST'S NAME.....

HOW LONG HAVE YOU BEEN GOING TO THE ABOVE DENTIST?.....Years

HOW OFTEN DO YOU GO TO YOUR DENTIST?

-Regular check ups
-Infrequently
-Only for Emergencies
-Never

WHEN WAS YOUR LAST DENTAL APPOINTMENT?

PAST

CURRENTLY

THUMB OR FINGER SUCKING	Yes	No .....	.....Yes	.....No
MOUTH BREATHING	Yes	No .....	.....yes	.....No
TOOTH GRINDING OR CLENCHING	Yes	No .....	.....Yes	.....No
DIFFICULTY IN CHEWING	Yes	NoYesNo
SPEECH PROBLEM	Yes	NoYesNo

PLEASE EXPLAIN ALL "YES" ANSWERS.....

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