#### PATIENT INFORMATION

PATIENT NAME:_						_	Single	Minor	Male	Female
Preferred Name	LAST				MIDDLE		_ 0	Birth		
Address				_ City		State			Zip	
Birthdate	DAY	YEAR	SSN							
Telephone (Mobile)				(Work)			(Home)			
If Rogue Dental is unal	ble to reach y	ou, at which numb	er(s) may we	leave a detailed	message? Home Cel	II Work Other_				
Would you like to receipt	ive text remir	nders? 🗌 YES 🛛	NO Em	ail corresponde	nce? 🗌 YES 🗌 NO					
Email					_ Employer:					
How did vou hear abou	ut our practic	e?								

# INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Subscriber Name	Subscriber Name
Subscriber ID	Subscriber ID
Date of Birth	Date of Birth
Relationship to Subscriber	Relationship to Subscriber □Self □Spouse □Child □Other
Employer Name	Employer Name
Employer Phone	Employer Phone
Insurance Company	Insurance Company
Insurance Group	Insurance Group #
Insurance Phone	Insurance Phone

Please present your insurance card to be photocopied for our records.

### RESPONSIBLE PARTY (If minor)

Last Name:			First:				Initial:
Address (if different)		City		State		Zip	
Date of Birth	_ SSN		Email				
Telephone (Home)		(Work)			(Mobile)		
EMERGENCY CONTACT OUT							

## 

Last Name:					_ First:	 Initial:
Telephone (	Mobile	□ Work	□ Home)			

### AUTHORIZATION AND RELEASE

- 1. I consent to the diagnostic procedures, including x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by my dentist to make a thorough diagnosis of my (or my child's) dental needs.
- 2. I further authorize my dentist to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that my dentist may choose and employ such assistance as deemed fit to provide recommended treatment.
- 3. I consent to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist or specialist, or for evaluating and administering any claims for insurance benefits.
- 4. I AUTHORIZE THE ASSIGNMENT OF MY INSURANCE BENEFITS TO RICHARD LEONG D.D.S. I understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance
- 5. ELECTRONIC COMMUNICATIONS. I consent to receiving HIPAA-compliant electronic communications as indicated in my preferences above. I understand that there is no obligation to receive these electronic communications. Message/data rates may apply, and I may opt-out of receiving electronic communications at any time.

### **HEALTH HISTORY**

Physician's NameAddress	2.	<ol> <li>Are you having pain or discomfort at this time?</li> <li>Have you been a patient in the hospital during the past two years?</li> <li>Have you been under the care of a medical doctor during the past two years?</li> </ol>						
4. Have you taken any medication or drugs during the past two years?       YES       NO         5. Are you now taking any medication, drugs or pills?       YES       NO         6. Are you aware of being allergic or have you ever reacted adversely to any medication or substance?       YES       NO         if yes, please list:		Physician's NamePhone NoPhone No						
5. Are you now taking any medication, drugs or pills?       YES       NO         If yes, please list.								
6. Are you aware of being allergic or have you ever reacted adversely to any medication or substance?       YES       NO         If yes, please list:								
If yes, please list:								
7. Are you aware of being allergic or have you ever reacted adversely to latex, vinyl or rubber?       YES       NO         8. Indicate which of the following you have had or have at present. Circle "yes" or "no' to each item.       Heart Failure	6.	Are you aware of being allergic or have you ever reacted adversely to any medication or substance?	YES	NO				
8. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.         Heart Tailure       YES       NO         Heart Tisease or Attack. YES       NO       Kifricial Joints (hip, knee, etc.) YES       NO         Angina Pectoris       YES       NO       Kifricial Joints (hip, knee, etc.) YES       NO         Congenital Heart Disease YES       NO       Ulcers       YES       NO         Heart Murmur       YES       NO       Glaucoma       YES       NO         High Blood Pressure       YES       NO       Glaucoma       YES       NO         High Blood Pressure       YES       NO       Congenital Heart Valve       YES       NO         Mitral Valve Prolapse       YES       NO       Emphysema       YES       NO       Arterioscierosis       YES       NO         Heart Surgery       YES       NO       Tuberculosis       YES       NO       Faruise Easily       YES       NO         Heart Surgery       YES       NO       Attribute       YES       NO       Faruise Easily       YES       NO         Heart Surgery       YES       NO       Haucoma       YES       NO       Faruise Easily       YES       NO         Heart Surge								
Heart Failure       YES       NO       Artificial Joints (hip, knee, etc.) YES       NO       Hepatitis B (serum)       YES       NO         Heart Disease or Attack       YES       NO       Kidney Trouble       YES       NO       Venereal Disease       YES       NO         Angian Pectoris       YES       NO       Diabetes       YES       NO       Al.D.S.       YES       NO         Heart Murmur       YES       NO       Diabetes       YES       NO       Heard Niewer Blisters       YES       NO         Heart Alwurmur       YES       NO       Glaucoma       YES       NO       Hemophilia       YES       NO         High Blood Pressure       YES       NO       Cosmetic Surgery       YES       NO       Hemophilia       YES       NO         Mitral Valve Prolapse       YES       NO       Cosmetic Surgery       YES       NO       Artificial Heart Valve       YES       NO       Chronic Cough       YES       NO       Heart Bacemaker       YES       NO       Thereumatic Fever       YES       NO       Heart Bacemaker       YES       NO       Thereumatic Fever       YES       NO       Thereumatics       YES       NO       Theloreuse Preso       No       Theloreuse Preso <td></td> <td></td> <td>YES</td> <td>NO</td>			YES	NO				
Heart Disease or Attack. YES NO       Kidney Trouble       YES NO       Venereal Disease       YES NO         Angina Pectoris       YES NO       Diabetes       YES NO       Cold Sores/Fever Blisters       YES NO         Heart Murmur       YES NO       Thyroid Problems       YES NO       Cold Sores/Fever Blisters       YES NO         High Blood Pressure       YES NO       Cosmetic Surgery       YES NO       Hemophilia       YES NO         Arteriosclerosis       YES NO       Cosmetic Surgery       YES NO       Anemia       YES NO         Artificial Heart Valve       YES NO       Chronic Cough       YES NO       Sickle Cell Disease       YES NO         Heart Surgery       YES NO       Tuberculosis       YES NO       Bruise Easily       YES NO         Heart Surgery       YES NO       Anternia       YES NO       Fever       YES NO         Heart Surgery       YES NO       Hay Fever       YES NO       Fever       YES NO         Rheumatic Fever       YES NO       Altergies or Hives       YES NO       Feilepsy or Seizures       YES NO         Rheumatism       YES NO       Sinus Trouble       YES NO       Feilepsy or Seizures       YES NO         Rheumatism       YES NO       Radiation Therapy       YES NO<	8.							
Angina Pectoris.       YES       NO       Ulcers       YES       NO       A.I.D.S.       YES       NO         Congenital Heart Disease       YES       NO       Thyroid Problems       YES       NO       Cold Sores/Fever Blisters. YES       NO         High Blood Pressure       YES       NO       Glaucoma       YES       NO       Hemophilia       YES       NO         Arteriosclerosis       YES       NO       Cosmetic Surgery.       YES       NO       Anemia       YES       NO         Arteriosclerosis       YES       NO       Emphysema       YES       NO       Sickle Cell Disease       YES       NO         Heart Surgery       YES       NO       Asthma       YES       NO       Epileps or Seizures       YES       NO         Rheumatic Fever       YES       NO       Asthma       YES       NO       Fainting or Dizzy Spells       YES       NO         Rheumatism       YES       NO       Addiation Therapy       YES       NO       Fainting or Dizzy Spells       YES       NO         Drug Addiction       YES       NO       Addiation Therapy       YES       NO       Developmentally Disabled       YES       NO         Do you walk up stairs o								
Congenital Heart Disease       YES       NO       Diabetes       YES       NO       Blood Transfusion       YES       NO         Heart Murmur       YES       NO       Thyroid Problems       YES       NO       Blood Transfusion       YES       NO         High Blood Pressure       YES       NO       Cosmetic Surgery       YES       NO       Anemia       YES       NO         Mitral Valve Prolapse       YES       NO       Chronic Cough       YES       NO       Sickle Cell Disease       YES       NO         Heart Surgery       YES       NO       Tuberculosis       YES       NO       Blood Transfusion       YES       NO         Heart Surgery       YES       NO       Chronic Cough       YES       NO       Bruise Easily       YES       NO         Heart Surgery       YES       NO       Tuberculosis       YES       NO       Epilepsy or Seizures       YES       NO         Rheumatis       YES       NO       Allergies or Hives       YES       NO       Epilepsy or Seizures       YES       NO         Rotanatism       YES       NO       Radiation Therapy       YES       NO       Beroinserist       YES       NO         Drug Addictio								
Hear Murmur.       YES       NO       Thyroid Problems.       YES       NO       Blood Transfusion       YES       NO         High Blood Pressure       YES       NO       Glaucoma       YES       NO       Hemophilia       YES       NO         Arteriosclerosis       YES       NO       Cosmetic Surgery.       YES       NO       Anemia       YES       NO         Artificial Heart Valve       YES       NO       Chronic Cough       YES       NO       Bruise Easily.       YES       NO         Heart Surgery       YES       NO       Athiticial Heart Valve       YES       NO       Athiticial Heart Valve       YES       NO       Athiticial Heart Valve       YES       NO       Tuberculosis       YES       NO       Liver Disease       YES       NO         Heart Surgery       YES       NO       Athital Xalve       YE		•						
High Blood Pressure       YES       NO       Glaucoma       YES       NO       Hemphilia       YES       NO         Arteriosclerosis       YES       NO       Emphysema       YES       NO       Sickle Cell Disease       YES       NO         Artificial Heart Valve       YES       NO       Chronic Cough       YES       NO       Bruise Easily       YES       NO         Heart Pacemaker       YES       NO       Asthma       YES       NO       Expression       YES       NO         Heart Pacemaker       YES       NO       Asthma       YES       NO       Expression       YES       NO         Heart Surgery       YES       NO       Asthma       YES       NO       Epilepsy or Seizures       YES       NO         Arthritis       YES       NO       Allergies or Hives       YES       NO       Reining or Dizzy Spells       YES       NO         Rheumatism       YES       NO       Radiation Therapy       YES       NO       Psychiatric Treatment       YES       NO         Cortisone Medicine       YES       NO       Heapatitis A (infectious)       YES       NO       Psychiatric Treatment       YES       NO         Stroke								
Arteriosclerosis       YES       NO       Cosmetic Surgery       YES       NO       Anemia       YES       NO         Mitral Valve Prolapse       YES       NO       Emphysema       YES       NO       Sickle Cell Disease       YES       NO         Artificial Heart Valve       YES       NO       Tuberculosis       YES       NO       Liver Disease       YES       NO         Heart Pacemaker       YES       NO       Asthma       YES       NO       Liver Disease       YES       NO         Heart Surgery       YES       NO       Asthma       YES       NO       Epilepsy or Seizures       YES       NO         Rheumatic Fever       YES       NO       Allergies or Hives       YES       NO       Fainting or Dizzy Spells       YES       NO         Arthritis       YES       NO       Radiation Therapy       YES       NO       Psychiatric Treatment       YES       NO         Drug Addiction       YES       NO       Chemotherapy       YES       NO       Developmentally Disabled       YES       NO         Stroke       Stroke       NO       Hepatitis A (infectious)       YES       NO       Evelopmentally Disabled       YES       NO								
Mitral Valve Prolapse       YES       NO       Emphysema       YES       NO       Sickle Cell Disease       YES       NO         Artificial Heart Valve       YES       NO       Chronic Cough       YES       NO       Bruise Easily       YES       NO         Heart Surgery       YES       NO       Asthma       YES       NO       Ever Cuosis       YES       NO         Rheumatic Fever       YES       NO       Allergies or Hives       YES       NO       Fainting or Dizzy Spelis       YES       NO         Arthritis       YES       NO       Allergies or Hives       YES       NO       Fainting or Dizzy Spelis       YES       NO         Arthritis       YES       NO       Radiation Therapy       YES       NO       Nervousness       YES       NO         Cortisone Medicine       YES       NO       Radiation Therapy       YES       NO       Developmentally Disabled       YES       NO         9. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shorthess of breath, or because you are very tired?       YES       NO         10. Do you use more than two pillows to sleep?       YES       YES       NO         11. Do you use more than two pillows to sleep?       YES <t< td=""><td></td><td></td><td></td><td></td></t<>								
Artificial Heart Valve       YES       NO       Chronic Cough       YES       NO       Bruise Easily       YES       NO         Heart Pacemaker       YES       NO       Tuberculosis       YES       NO       Liver Disease       YES       NO         Heart Surgery       YES       NO       Asthma       YES       NO       Yellow Jaundice       YES       NO         Rheumatic Fever       YES       NO       Hay Fever       YES       NO       Epilepsy or Seizures       YES       NO         Arthritis       YES       NO       Sinus Trouble       YES       NO       Painting or Dizzy Spells       YES       NO         Rheumatism       YES       NO       Radiation Therapy       YES       NO       No       Norvousness       YES       NO         Storke       YES       NO       Hepatitis A (infectious)       YES       NO       Developmentally Disabled       YES       NO         9. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?       YES       NO         10. Do you use more than two pillows to sleep?       YES       NO       YES       NO         11. Do you use more than two pillows to sleep?       YES				NO				
Heart Pacemaker       YES       NO       Tuberculosis       YES       NO       Liver Disease       YES       NO         Heart Surgery       YES       NO       Astma       YES       NO       Yellow Jaundice       YES       NO         Rheumatic Fever       YES       NO       Hay Fever       YES       NO       Epilepsy or Seizures       YES       NO         Arthritis       YES       NO       Allergies or Hives       YES       NO       Fainting or Dizzy Spells       YES       NO         Rheumatism       YES       NO       Radiation Therapy       YES       NO       Psychiatric Treatment       YES       NO         Drug Addiction       YES       NO       Chemotherapy       YES       NO       Developmentally Disabled       YES       NO         9.       When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?       YES       NO       YES       NO         10.       Do your ankles swell during the day?       YES       NO       YES       NO         11.       Do you ever wake up from sleep and feel short of breath       YES       NO       YES       NO         12.       Have you nost cidediet       YES		Artificial Heart Valve		NO				
Rheumatic Fever       YES       NO       Hay Fever       YES       NO       Epilepsy or Seizures       YES       NO         Arthritis       YES       NO       Allergies or Hives       YES       NO       Fainting or Dizzy Spells       YES       NO         Rheumatism       YES       NO       Sinus Trouble       YES       NO       Nervousness       YES       NO         Cortisone Medicine       YES       NO       Radiation Therapy       YES       NO       Psychiatric Treatment       YES       NO         Drug Addiction       YES       NO       Chemotherapy       YES       NO       Psychiatric Treatment       YES       NO         Stroke       YES       NO       Hepatitis A (infectious)       YES       NO       Developmentally Disabled       YES       NO         9.       When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?       YES       NO         10.       Do you use more than two pillows to sleep?       YES       NO         12.       Have you lost or gained more than 10 pounds in the past year?       YES       NO         13.       Do you ever wake up from sleep and feel short of breath       YES       NO		Heart Pacemaker	YES	NO				
Arthritis       YES       NO       Allérgies or Hives       YES       NO       Fåinting or Dizzy Spells       YES       NO         Rheumatism       YES       NO       Sinus Trouble       YES       NO       Nervousness       YES       NO         Cortisone Medicine       YES       NO       Radiation Therapy       YES       NO       Nervousness       YES       NO         Drug Addiction       YES       NO       Chemotherapy       YES       NO       Psychiatric Treatment       YES       NO         Stroke       YES       NO       Hepatitis A (infectious)       YES       NO       Developmentally Disabled       YES       NO         9.       When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?       YES       NO       YES       NO         10.       Do you use more than two pillows to sleep?       YES       NO       YES       NO         12.       Have you lost or gained more than 10 pounds in the past year?       YES       NO       YES       NO         13.       Do you ever wake up from sleep and feel short of breath       YES       NO       YES       NO         14.       Are you na special diet       YES		Heart Surgery		NO				
Rheumatism       YES       NO       Sinus Trouble       YES       NO       Nervousness       YES       NO         Cortisone Medicine       YES       NO       Radiation Therapy       YES       NO       Psychiatric Treatment       YES       NO         Drug Addiction       YES       NO       Hepatitis A (infectious)       YES       NO       Psychiatric Treatment       YES       NO         Stroke       YES       NO       Hepatitis A (infectious)       YES       NO       Developmentally Disabled       YES       NO         9. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?       YES       NO         10. Do your ankles swell during the day?       YES       NO       YES       NO         11. Do you use more than two pillows to sleep?       YES       NO       YES       NO         12. Have you lost or gained more than 10 pounds in the past year?       YES       NO       YES       NO         13. Do you ever wake up from sleep and feel short of breath       YES       NO       YES       NO         14. Are you pregnant?       YES       NO       YES       NO         15. Has your medical doctor ever said you have a cancer or tumor?       YES       NO								
Cortisone Medicine       YES       NO       Radiation Therapy       YES       NO       Psychiatric Treatment       YES       NO         Drug Addiction       YES       NO       Chemotherapy       YES       NO       Developmentally Disabled       YES       NO         9. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?       YES       NO         10. Do your ankles swell during the day?       YES       NO       YES       NO         11. Do you use more than two pillows to sleep?       YES       NO       YES       NO         12. Have you lost or gained more than 10 pounds in the past year?       YES       NO       YES       NO         13. Do you ever wake up from sleep and feel short of breath       YES       NO       YES       NO         14. Are you on a special diet       YES       NO       YES       NO         15. Has your medical doctor ever said you have a cancer or tumor?       YES       NO         16. Are you pregnant?       YES       NO       YES       NO         17. Do you have or have you had any disease, condition, or problem not listed       YES       NO         17. Do you have or have you had any disease, condition, or problem the with dental care in a safe and efficient manner.								
Drug Addiction       YES       NO       Chemotherapy       YES       NO       Developmentally Disabled       YES       NO         9. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?       YES       NO         10. Do your ankles swell during the day?       YES       NO       YES       NO         11. Do you use more than two pillows to sleep?       YES       NO         12. Have you lost or gained more than 10 pounds in the past year?       YES       NO         13. Do you ever wake up from sleep and feel short of breath       YES       NO         14. Are you on a special diet       YES       NO         15. Has your medical doctor ever said you have a cancer or tumor?       YES       NO         16. Are you pregnant?       YES       NO         17. Do you have or have you had any disease, condition, or problem not listed       YES       NO         16. Are you pregnant?       YES       NO         17. Do you have or have you had any disease, condition, or problem not listed       YES       NO         17. Do you have or information is necessary to provide me with dental care in a safe and efficient manner.       I have answered all questions truthfully and to the best of my knowledge.								
Stroke       YES NO       Hepatitis A (infectious)       YES NO         9. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?       YES NO         10. Do your ankles swell during the day?       YES NO         11. Do you use more than two pillows to sleep?       YES NO         12. Have you lost or gained more than 10 pounds in the past year?       YES NO         13. Do you ever wake up from sleep and feel short of breath       YES NO         14. Are you on a special diet       YES NO         15. Has your medical doctor ever said you have a cancer or tumor?       YES NO         16. Are you pregnant?       YES NO         17. Do you have or have you had any disease, condition, or problem not listed       YES NO         17. Do you have or have you had any disease, condition, or problem not listed       YES NO         17. Jo you have or have you had any disease, condition, or problem not listed       YES NO         16. Are you pregnant?       YES NO         17. Jo you have or have you had any disease, condition, or problem not listed       YES NO         17. Judgest list       I         18. Have answered all questions truthfully and to the best of my knowledge.       YES NO								
9. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?       YES       NO         10. Do your ankles swell during the day?       YES       NO         11. Do you use more than two pillows to sleep?       YES       NO         12. Have you lost or gained more than 10 pounds in the past year?       YES       NO         13. Do you ever wake up from sleep and feel short of breath       YES       NO         14. Are you on a special diet       YES       NO         15. Has your medical doctor ever said you have a cancer or tumor?       YES       NO         16. Are you pregnant?       YES       NO         17. Do you have or have you had any disease, condition, or problem not listed       YES       NO         16. Are sup pregnant?       YES       NO         17. Do you have or have you had any disease, condition, or problem not listed       YES       NO         16. If yes, please list       YES       NO         17. Inderstand the above information is necessary to provide me with dental care in a safe and efficient manner.       I have answered all questions truthfully and to the best of my knowledge.			a ies	NO				
shortness of breath, or because you are very tired?       YES       NO         10. Do your ankles swell during the day?       YES       NO         11. Do you use more than two pillows to sleep?       YES       NO         12. Have you lost or gained more than 10 pounds in the past year?       YES       NO         13. Do you ever wake up from sleep and feel short of breath       YES       NO         14. Are you on a special diet       YES       NO         15. Has your medical doctor ever said you have a cancer or tumor?       YES       NO         16. Are you pregnant?       YES       NO         17. Do you have or have you had any disease, condition, or problem not listed       YES       NO         17. Do you have or have you had any disease, condition, or problem not listed       YES       NO         17. Jo you have or have you had any disease, condition, or problem not listed       YES       NO         If yes, please list	0							
10. Do your ankles swell during the day?       YES       NO         11. Do you use more than two pillows to sleep?       YES       NO         12. Have you lost or gained more than 10 pounds in the past year?       YES       NO         13. Do you ever wake up from sleep and feel short of breath       YES       NO         14. Are you on a special diet       YES       NO         15. Has your medical doctor ever said you have a cancer or tumor?       YES       NO         16. Are you pregnant?       YES       NO         17. Do you have or have you had any disease, condition, or problem not listed       YES       NO         16. Are sole pregnant?       YES       NO         17. Do you have or have you had any disease, condition, or problem not listed       YES       NO         16. Are sole pregnant?       YES       NO         17. Do you have or have you had any disease, condition, or problem not listed       YES       NO         16. If yes, please list	9.		VES	NO				
11. Do you use more than two pillows to sleep?       YES       NO         12. Have you lost or gained more than 10 pounds in the past year?       YES       NO         13. Do you ever wake up from sleep and feel short of breath       YES       NO         14. Are you on a special diet       YES       NO         15. Has your medical doctor ever said you have a cancer or tumor?       YES       NO         16. Are you pregnant?       YES       NO         17. Do you have or have you had any disease, condition, or problem not listed       YES       NO         16. Are stand the above information is necessary to provide me with dental care in a safe and efficient manner.       I have answered all questions truthfully and to the best of my knowledge.       NO	10							
12. Have you lost or gained more than 10 pounds in the past year?       YES       NO         13. Do you ever wake up from sleep and feel short of breath       YES       NO         14. Are you on a special diet       YES       NO         15. Has your medical doctor ever said you have a cancer or tumor?       YES       NO         16. Are you pregnant?       YES       NO         17. Do you have or have you had any disease, condition, or problem not listed       YES       NO         17. Do you have or have you had any disease, condition, or problem not listed       YES       NO         16 Are support the above information is necessary to provide me with dental care in a safe and efficient manner.       I understand the above information is necessary to provide me with dental care in a safe and efficient manner.								
13. Do you ever wake up from sleep and feel short of breath       YES       NO         14. Are you on a special diet       YES       NO         15. Has your medical doctor ever said you have a cancer or tumor?       YES       NO         16. Are you pregnant?       YES       NO         17. Do you have or have you had any disease, condition, or problem not listed       YES       NO         17. Do you have or have you had any disease, condition, or problem not listed       YES       NO         16. Are state list       YES       NO         17. Do you have or have you had any disease, condition, or problem not listed       YES       NO         16. If yes, please list       YES       NO         17. Inderstand the above information is necessary to provide me with dental care in a safe and efficient manner.       NO         18. Have answered all questions truthfully and to the best of my knowledge.       NO								
14. Are you on a special diet       YES       NO         15. Has your medical doctor ever said you have a cancer or tumor?       YES       NO         16. Are you pregnant?       YES       NO         17. Do you have or have you had any disease, condition, or problem not listed       YES       NO         17. Do you have or have you had any disease, condition, or problem not listed       YES       NO         16. Are you pregnant?       YES       NO         17. Do you have or have you had any disease, condition, or problem not listed       YES       NO         16. Jump disease list       YES       NO         17. Inderstand the above information is necessary to provide me with dental care in a safe and efficient manner.       I have answered all questions truthfully and to the best of my knowledge.								
15. Has your medical doctor ever said you have a cancer or tumor?       YES       NO         16. Are you pregnant?       YES       NO         17. Do you have or have you had any disease, condition, or problem not listed       YES       NO         17. Do you have or have you had any disease, condition, or problem not listed       YES       NO         If yes, please list       YES       NO         I understand the above information is necessary to provide me with dental care in a safe and efficient manner.       I have answered all questions truthfully and to the best of my knowledge.	13.	Do you ever wake up from sleep and feel short of breath	YES	NO				
16. Are you pregnant?       YES       NO         17. Do you have or have you had any disease, condition, or problem not listed       YES       NO         17. Do you have or have you had any disease, condition, or problem not listed       YES       NO         If yes, please list       YES       NO         I understand the above information is necessary to provide me with dental care in a safe and efficient manner.       I have answered all questions truthfully and to the best of my knowledge.	14.	Are you on a special diet	YES	NO				
17. Do you have or have you had any disease, condition, or problem not listed	15.	Has your medical doctor ever said you have a cancer or tumor?	YES	NO				
17. Do you have or have you had any disease, condition, or problem not listed	16.	Are you pregnant?	YES	NO				
If yes, please list				NO				
I have answered all questions truthfully and to the best of my knowledge.								
I have answered all questions truthfully and to the best of my knowledge.								
I have answered all questions truthfully and to the best of my knowledge.								
Patient Signature Date			mannei	r.				
Patient Signature Date								
	Pa	tient Signature Date						

Parent or Responsible Party \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Dr. Evaluation \_\_\_\_\_ Date \_\_\_\_\_

Comment \_\_\_\_\_