				_DATE			
DATE OF BIR	RTH			AGE			
REFERRING I	DENTIST or CLI	NIC:					
PHARMACY:							
		SPECK END	ODONTICS, LLC				
		ATION AND HEALTH HISTORY . PLEA	SE COMPLETE THE FOLLOWING CONFIDE	NTIAL INFORMA	TION		
Please circ	cle any of the	following you have had or pro	esently have:				
Heart Failure		Drug Addiction	Hay Fever	Mitral Valve I	Prolapse		
Heart Disease		Stroke Allergies or Hives		Hemophilia			
Angina Pecto		Developmentally Disabled	Sinus Trouble	Anemia			
Congenital H		Swollen Ankles	Radiation Therapy	Sickle Cell Di			
Heart Murmu High Blood Pr		Artificial Joint	Chemotherapy	Liver Disease			
Arterioscleros		Kidney Trouble Ulcers	Cancer Emphysema	Yellow Jauno			
Artificial Hear		Diabetes	Prolonged Bleeding	Epilepsy or S Fainting or D			
Heart Pacema		Thyroid Problems	Hepatitis A (Infectious)	Nervousness			
Heart surgery	,	Glaucoma	Hepatitis B	Psychiatric Tr			
Rheumatic Fe	ver	Cosmetic Surgery	Hepatitis C (Chronic)	Shortness of			
Arthritis		Chronic Cough	AIDS	Lupus			
Rheumatism	200	Tuberculosis	H.I.V. Positive	Dry Mouth			
Cortisone Medicine		Asthma	Blood Transfusion	Herpes			
				NKDA	NCAN	CAN	
EMERGENCY CO	ONTACT:				ITCAIT	Criiv	
	Dless	d Deceases	Descination				
	ВІОО	d Pressure	Respiration				
1.	Do you have o	r have you had any disease or co	ondition not listed?	YES	NO		
	If yes, please lis		The first fi	123	110		
		11 11 11 11 11 11 11 11 11 11 11 11 11	?	YES	NO		
2.	Are you naving	g pain or discomfort at this time		TES	NO		
	$(\ldots)$	$(\ldots)(\ldots)(\ldots)(\ldots)$	Salasta Nissahas Ota 10				
	99		Select a Number 0 to 10:				
	NO HUNTS LITTLE BIT	HURTS HURTS HURTS HURTS HURTS WORSTY					
3.	Have you been	a patient in the hospital during	the past two years?	YES	NO		
4. Have you bee		under the care of a medical do	ctor during the past				
	two years? Ph	ysician's Name		YES	NO		
			oills?	YES	NO		
			71131	123	110		
6.	Are you aware	of being allergic to or have you	ever reacted adversly				
		tion or substance?		YES	NO		
				,,,,			
	yes, pieuse iis						
7.	Reaction to loc	cal anesthetic?		YES	NO		
Drognant?			sing? VES NO Birth control		NO		

DATIENT NAME				MA	LE	FEMALE
ADDRESS					DATE_	
CITY			STATE		ZIP	
DHONE H (	1	C ( )		_ W (	)	
DATE OF BIRTH		AGE	SOCIAL SECUF	RITY #		
OCCUPATION		E	MPLOYER			
		PRIMARY DENTA				
INSURANCE COM	MPANY		GROUP NA	ME		
POLICY HOLDER	'S NAME		ID# (	OR SS#		
DATE OF BIRTH_	J 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	_GROUP #	EFFE	CTIVE DAT	E	
		SECONDARY DENT	TAL INSURANCE			
INSURANCE COM	MPANY		GROUP NA	ME		
POLICY HOLDER	'S NAME		ID#0	OR SS#		
DATE OF BIRTH		_GROUP #	EFFE	CTIVE DAT	E	
	ACCOUNT INFORMATI	ON - PERSON FINA	NCIALLY RESPONS	IBLE FOR	ACCOUN	Т
NAME			RELATION:	SHIP TO PA	TIENT	
ADDRESS		CITY			IAIE	ZIP
PHONE H (	)	C ()		_ W (	)	
DATE OF BIRTH_	,		SOCIAL SECURITY	/#		-
The unders	signed hereby authorizes	doctor to take x-rays	, study models, pho	otographs, dental nee	or any o	ther diagnostic aid
1. The unders deemed ap 2. I also author medication that using a and conser 3. Our office disclose an	signed hereby authorizes of propriate by doctor to make orize doctor to perform all romand therapy indicated for anesthetic agents embodied that the doctor choose a policy is to keep every pattern sensitive information to	doctor to take x-rays ke a thorough diagnor ecommended treatm r such treatment in co s a certain risk and end and employ such assistient's medical/dental anyone other than m	ent mutually agreed onnection with the dodontic instrument stance as deemed fill and personal informedical/dental or ins	dental nee d upon by r above me ts may sep t to provid mation pri surance pe	ds. me and to ntioned p arate.Fur e recomn vate. It is rsonnel w	use the appropriate patient. I understand thermore, I authorize nended treatment. Our intention not to working directly with
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