Patient Information (CONFIDENTIAL) Date	WIL			we will be happy to help.
Patient Information (CONFIDENTIAL) Name				Patient #
Name Birthdate Home Plone State Prov. Prov. Prov. State Prov. Prov. Prov. State Prov. Prov. Prov. State Prov	D.C. LT.C.			SS#/SIN
Email	Patient Injor	mation (CONFI	DENTIAL)	Date
Email	Name		Birthdate	Home Phone
Check Appropriate Box Minor Single Married Divorced Widowed Separated Full Student, Name of School/College City Prov. Full Time Time Time Time Time Student, Name of School/College City Prov.	Address		City	State/ 21p/ Prov P.C
Patient or Parent/Guardian's Employer State Business Address City Prov. PC State Spouse or Parent/Guardian's Name Whom may we thank for referring you? Person to contact in case of emergency Phome Responsible Party Name of Person Responsible for this Account Address Home Phone Employer Birthdate Employer Birthdate Employer Work Phone Birthdate Employer Work Phone SS#/SIN St shis person currently a patient in our office? Yes No For your convenience, we offer the following methods of payment. Please check the option you prefex Payment in full at each appointment. Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy. Insurance Information Name of Insured SS#/SIN Date Employer Union or Local # State Address of Employer City Prov PC DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No If YES, COMPLETE THE FOLLOWING: Name of Employer Union or Local # State SS#/SIN Date Employed Max. annual benefit DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No If YES, COMPLETE THE FOLLOWING: Name of Employer City Prov PC State First Stat	Email			Cell Phone
Patient or Parent/Guardian's Employer State Business Address City Prov. PC State Spouse or Parent/Guardian's Name Whom may we thank for referring you? Person to contact in case of emergency Phome Responsible Party Name of Person Responsible for this Account Address Home Phone Employer Birthdate Employer Birthdate Employer Work Phone Birthdate Employer Work Phone SS#/SIN St shis person currently a patient in our office? Yes No For your convenience, we offer the following methods of payment. Please check the option you prefex Payment in full at each appointment. Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy. Insurance Information Name of Insured SS#/SIN Date Employer Union or Local # State Address of Employer City Prov PC DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No If YES, COMPLETE THE FOLLOWING: Name of Employer Union or Local # State SS#/SIN Date Employed Max. annual benefit DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No If YES, COMPLETE THE FOLLOWING: Name of Employer City Prov PC State First Stat	Check Appropriate Box: M	inor Single Married [☐ Divorced ☐ Widowed ☐	Separated ,
Patient or Parent/Guardian's Employer State Business Address City Prov. PC State Spouse or Parent/Guardian's Name Whom may we thank for referring you? Person to contact in case of emergency Phome Responsible Party Name of Person Responsible for this Account Address Home Phone Employer Birthdate Employer Birthdate Employer Work Phone Birthdate Employer Work Phone SS#/SIN St shis person currently a patient in our office? Yes No For your convenience, we offer the following methods of payment. Please check the option you prefex Payment in full at each appointment. Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy. Insurance Information Name of Insured SS#/SIN Date Employer Union or Local # State Address of Employer City Prov PC DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No If YES, COMPLETE THE FOLLOWING: Name of Employer Union or Local # State SS#/SIN Date Employed Max. annual benefit DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No If YES, COMPLETE THE FOLLOWING: Name of Employer City Prov PC State First Stat	If Student, Name of School/Col	lege	City	State/ Prov Full Part Time Time
Spouse or Parent/Guardian's Name	Patient or Parent/Guardian's E	mplover		Work Phone
Spouse or Parent/Guardian's Name	Business Address		City	State/ 21p/ Prov. P.C.
Phone Person to contact in case of emergency Phone Responsible Party Relationship to Patient Address Home Phone Cell Phone Provensible P				
Responsible Party Name of Person Responsible for this Account Address	Whom may we thank for refer	ring you?		v
Responsible Party Name of Person Responsible for this Account Address	Person to contact in case of em	nergency		Phone
Name of Person Responsible for this Account Address				
Name of Person Responsible for this Account Address	-			Relationship
Email Cell Phone Driver's License# Birthdate Financial Institution Employer Work Phone SS#/SIN Is this person currently a patient in our office? Yes No For your convenience, we offer the following methods of payment. Please check the option you prefer Payment in full at each appointment. Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy. Insurance Information Relationship to Patient				to Patient
Driver's License# Birthdate Financial Institution SS#/SIN				
Employer				
Is this person currently a patient in our office?				
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment. Cash	Employer		Work Phone	SS#/SIN
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Name of Insured SS#/SIN Date Employed State Stat	☐ Cash ☐ Personal (Check Credit Card V	ISA MasterCard I	wish to discuss the office's payment policy.
Name of Insured SS#/SIN Date Employed State Stat	Insurance In	formation		
Birthdate SS#/SIN Date Employed Name of Employer Union or Local # Work Phone State/ Zip/ Prov. P.C. Insurance Company Group # Policy/ID # State/ Zip/ Prov. P.C. Insurance Company Group # Policy/ID # State/ Zip/ Prov. P.C. 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 FOLLOWING: Name of Insured Relationship to Patient Date Employed Date Employed Work Phone State/ State/ Zip/ Prov. P.C. Address of Employer Gity Prov. P.C. Insurance Company Group # Policy/ID # State/ Zip/ Prov. P.C. Insurance Company Group # Policy/ID # State/ Zip/ Prov. P.C. Insurance Company Group # Policy/ID # State/ Zip/ Prov. P.C.				Relationship
Name of Employer Union or Local # Work Phone State/ Zip/ Prov. P.C. Insurance Company Group # Policy/ID # State/ Zip/ Prov. P.C. 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 FOLLOWING: Name of Insured Relationship to Patient Birthdate SS#/SIN Date Employed Work Phone State/ Zip/ Prov. P.C. Address of Employer City Prov. P.C. Insurance Company Group # Policy/ID # State/ Zip/ Prov. P.C. Insurance Company Group # Policy/ID # State/ Zip/ Prov. P.C.	A STATE OF THE PARTY OF THE PAR			
Address of Employer				
Insurance Company Group # Policy/ID # State/ Zip/ Prov. P.C. 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 FOLLOWING: Name of Insured Relationship to Patient Date Employed Date Employed Work Phone State/ Zip/ Prov. P.C. Address of Employer Gity Prov. P.C. Insurance Company Group # Policy/ID # State/ Zip/ Prov. P.C. City Prov. P.C.	Name of Employer		Union or Local #	State/ Zip/
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Relationship to Patient	How much is your deductible	? How much	1 have you used?	Max. annual benefit
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Address of Employer City State/Prov. Zip/Prov. P.C. Insurance Company Group # Policy/ID # State/State/Prov. Zip/Prov. P.C. Ins. Co. Address City Prov. P.C. P.C.				Work Phone
Insurance Company Group # Policy/ID # Ins. Co. Address City Prov. P.C.				State/ Zin/
Ins. Co. Address City Prov_ P.C				
	The second secon			State/ Zip/

Over Please

Patient Medical Histo								
Physician	Office Phone	21				Date of Last Exam		
1. Are you under medical treatment now?	Yes	No	10. Are v	ou wed	aring c	ontact lenses?	Yes	No.
2. Have you ever been hospitalized for any			11. Are yo	ou allerg	ic to or l	have you had any reactions to the following:		
surgical operation or serious illness within the last 5	years?		Local	Anestl	hetics (e.g. Novocain)		
If yes, please explain						her Antibiotics		
2 4 1 1 1 1 1 1			Sulfa	Drugs			- -	=
3. Are you taking any medication(s)		П.						
including non-prescription medicine? If yes, what medication(s) are you taking?						······································		
if yes, what medication(s) are you taking:								
4. Have you ever taken Fen-Phen/Redux?	П.					ckel, mercury, etc.)		
5. Have you ever taken Fosamax, Boniva, Actonel or any c	ancer						. Ц	
medications containing bisphosphonates?					se list)			
6. Have you taken Viagra, Revatio, Cialis or Levitra		_	associa	u nave i sted wit	h a bna	tent cough or throat clearing not wn illness (lasting more than 3 weeks)?		
in the last 24 hours?	H	Щ.	13. Wom			mi uness (usung more mun 5 weeks):	_	
7. Do you use tobacco?		H			-	t or think you may be pregnant?		
		لسا	b) Are	you n	ursing	?		
9. Do you have or have you had any of the following?			c) Are	you to	aking o	ral contraceptives?		
Yes No			1	Yes 1	No		Yes	No
High Blood Pressure	Heart Disease					Chest Pains		- 🗀
Heart Attack	Cardiac Pacemak					Easily Winded		
Rheumatic Fever	Heart Murmur					Stroke		
Swollen Ankles	Angina					Hay Fever / Allergies		
Fainting / Seizures	Frequently Tired					Tuberculosis		
Asthma	Anemia		A second and second and			Radiation Therapy		
Low Blood Pressure	Emphysema		A CONTRACTOR OF THE PARTY OF TH			Glaucoma		
Epilepsy / Convulsions	Cancer					Recent Weight Loss		
Leukemia	Arthritis					Liver Disease	intended.	
	Joint Replacemen				4	Heart Trouble	1 7 7 7 7 7	
Kidney Diseases	Hepatitis / Jaundi					Respiratory Problems		
		tern J. Para	out of		100000			
AIDS or HIV Infection	Sexually Transmi					Mitral Valve Prolapse	Н	H
Thyroid Problem	Stomach Troubles					Other		
	Stomach Troubles							
Thyroid Problem	Stomach Troubles	s / Ulcer:						
Patient Dental History Name of Previous Dentist and Location	Stomach Troubles Yes		s	u have	freque	Other	Yes	No
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