REGISTRATION

PLEASE PRINT TO	HE FOLLOWING PERSO	NAL INFORMA		D MALE FEMALE
PATIENT'S NAME LAST, FIRST, MIDD	ILE			SINGLE MARRIED DIVORCED
RESIDENCE ADDRESS STREET	MANAGEM - 2 - 2			SEPARATED DWIDOWED
CITY	<u> </u>	ZIF	>	-
HOME TELEPHONE		1.121 m - 22.1	•	DATE OF BIRTH
PATIENT EMPLOYED BY	<u> </u>		BUSINESS PHON	NE .
BUSINESS ADDRESS	CITY			ZIP CODE
OCCUPATION	DRIVER'S LICENS	ENUMBER	SOCIAL SECUR	RITY NUMBER
NAME OF RELATIVE OR FRIEND NOT LIVING V	VITH YOU		TELEPHO	NE .
COMPLETE ADDRESS			RELATION	ISHIP
IF PATIENT IS	MARRIED, COMPLET	E THIS PORT	ION	
NAME OF SPOUSE	OCCUPATION		SOCIAL SI	ECURITY NUMBER
EMPLOYED BY		BUSINESS	S TELEPHONE	
BUSINESS ADDRESS	CITY			ZIP CODE
DRIVER'S LICENSE NUMBER				
IF PATIENT IS A MIN	IOR (UNDER 18), COM	MPLETE THIS I	PORTION	
PARENT OR PERSON WITH LEGAL CUSTODY	OCCUPATION	SOCIAL S	ECURITY NUMBER	
EMPLOYED BY		BUSINES	TELEPHONE	
BUSINESS ADDRESS	CITY		··· ··	ZIP CODE
DRIVER'S LICENSE NUMBER				
WHOM MAY WE THANK FOR REFERRING YOU?	-,,, , , , , , , , , , , , , , , , , ,			
PERSON RESPONSIBLE FOR THIS ACCOUNT				
ADDRESS				
ASSIGNMENT OF BENEFITS: I hereby assign a health plan to Drs. Bunkers & Lipkowskl. This ass of this assignment is to be considered as valid as not paid by said insurance. I hereby authorize sal	ilgnment will remain in an original. I understa	n effect until re and that I am fi	voked by me in writi nancially responsibl	ng. A photocopy le for all charges
Signed:				

DENTAL HISTORY

1. HAVE YOU COME TO THIS OFFICE FOR PAIN RI				E OR JAWS? YES	NO NO
WHERE?				YES	NO
IT HURTS WITH:				OR SWELLING? YES	NC
DHOT COLD SWEETS	CONSTANTLY			PMANENT TEETH? YES	NO
2. HOW LONG SINCE YOU'VE BEEN TO A DENTIST		D DECAY D GUA			.,-
3. DO YOU VISIT A DENTIST:				NS FROM AN EXTRACTION? YES	NO
☐ REGULARLY ☐ IRREGULA	ALY			E FOR A NEW DENTURE YES	NO
☐ ALMOST NEVER				EETH REMOVED?	
4. WHEN WAS YOUR LAST SET OF FULL MOUTH X	-RAYS?			S HAVE YOU HAD?	
5. HAVE YOU EVER BEEN TREATED FOR				DENTURES?	
GUM DISEASE?	YES NO			UF DENTURES? YES	NO
6. HOW OFTEN DO YOU BRUSH YOUR TEETH?				REBASED? YES	NO
7. DO YOUR GUMS BLEED WHEN YOU BRUSH?	YES NO			E ANSWER THE FOLLOWING:	
8. PLEASE CHECK ANY ITEMS BELOW THAT YOU I	JSE OFTEN:	22. DOES THE CHILD HAVE			
D HAND TOOTH BRUSH DELECTRIC	THUMB SUCKING IN NAIL BITING				
□ DENTAL FLOSS □ GUM STIM	ULATORS	☐ MOUTH BREATHING		☐ UNUSUAL SPEECH PATTERNS	
CI RUBBER TIPS	RAY (WATER-PIC)	23. DO YOU RECEIVE FLOUR			
9. HAVE YOU EVER HAD YOUR TEETH STRAIGHTE	NED? YES NO	□ WATER □ VITA	AMINS	C OTHER	
•	MEDICAL	. HISTORY			
24. HOW WOULD YOU DESCRIBE YOUR GENERAL HEAL		YES	NO	Reviewed by	
□ EXCELLENT □ GOOD □ FAIR □ POOP		saure YES	NO	Date	
25. HAVE REQUIRED MEDICAL TREATMENT IN THE	44. A Stroke	YES	NO	Reviewed by	
LAST YEAR YES	NO 45. Hepatitis	YES	NO	Date	
	46. Jaundice or Liv	er Disease YES	NO	Reviewed by	
26. NAME OF YOUR PHYSICIAN	47. Diabetes	YES	NO	Date	
		YES	NO		
27. PHYSICIAN'S PHONE NUMBER ()	49. Kidney Disease	· YES	NO	Reviewed by	
28. DATE OF YOUR LAST PHYSICAL	50. Thyroid Diseas	e or Goiter YES	NO	Date	
29. LIST ANY DRUGS OR MEDICINES YOU HAVE US	ED 51. Fainting Spells	or Convulsions YES	NO	Reviewed by	
IN THE PAST YEAR	52. Epilepsy	YES	NO	Date	
	53. Mental Disorde	ra YES	NO	Reviewed by	
	54. Drug Addiction	YES	NO	Date	
PO YOU HAVE OR HAVE YOU EVER HAD? (Circle)	55. Cancer	YES	NO	Reviewed by	
30. A reaction to or told not to take:	56. Chemotherapy	YES	NO	Date	
31. Antibiotics YES	NO 57. X-Ray or Cobal	t Therapy YES	NO		
32. Narcotics YES	NO 58. Do you smoke?	' YES	NO	Reviewed by	
33. Anesthetics YES	NO 59. Emphysema	YES	NO	Date	
34. Any Other Drug YES	NO 60. Allergies or Hiv	es YES	NO	Reviewed by	
35. Heart Problems , YES	NO 61. Asthma or Hay	Fever YES	NO	Date	
36. Heart Murmur YES	NO 62. Sinus Trouble	YES	NO	Reviewed by	
37. Rheumatic Fever YES	NO 63. AIDS or AIDS F	Related Complex YES	NO	Date	
36. Projapsed Heart Valve YES	NO 64. Venereal Diseas	ie YES	NO	Reviewed by	
39. Joint Replacement YES	NO IF YOU ARE FEMA	LE, ARE YOU NOW:		Date	
40. Prolonged Bleading from a Small Cut YES	NO 65. On bir	th control pills, YES	NO		
41. A Cardiac Pacemaker YES	NO 66. Pregna	int YES	NO		
NOTES:					
					
	· · · · · · · · · · · · · · · · · · ·	·		· · · · · · · · · · · · · · · · · · ·	
LOONE ON AS TRUE THE ABOVE					
I CONFIRM AS TRUE THE ABOVE HEALTH INFORMA	TION & IF THERE ARE AN	NY CHANGES I WILL NOTIFY TH	E DENT		
PATIENT'S SIGNATURE				DATE:	