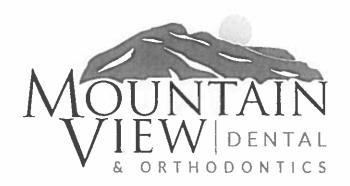


2081 East First Street * Alamogordo, New Mexico 88310

Patient Information:

Patient Name:				<u> </u>	
Last		First	MI	Preferred Nan	ne
Title: Mr./ Ms./ Mrs.		Gend	er: Male / Female		
Family Status: Married / Single	/ Child / Other				
Birth Date:					
Email Address:			ime to call:		
Phone:					
			Mobile	Othe	r
Address: City:					
•	Jtate.				
Employer Name:				22	
Address:					
City:	State:	- 1 1100	Zip:		
Responsible Party Info	ormation:				
This only needs to be filled out if the			patient, or if the patient is u	nder 18.	
Patient Name: Last	First		MI Prefe	erred Name	_
Title: Mr./ Ms./ Mrs.					
Family Status: Married / Single			·		
Birth Date:				337	
Email Address:	1 100 100 100	Best t	ime to call:	17 17 18 18 18 18 18 18 18 18 18 18 18 18 18	
Phone:	1 = = ==			LAND FR	
Home Address:	Work	Ext	Mobile	Oth	er
City:	State:		Zip:		
Primary Dental Insurance:			Secondary Dental Insi	ırance:	
Name of Insured:			Name of Insured:		
Insured Social:	Insured DOB:		Insured Social:	Insured D	ОВ:
Patient relationship to insured	:		Patient relationship to	insured:	
Insurance Plan Name:					
Insurance Company:					
Insurance Subscriber ID:					
Employer of Insured:			Employer of Insured:		
-	<u>* 2</u>				
How did you hear about our pr	actice?				
Family / Friend Rad	io Postca	rd in the Mail	Movie Theater	Website	Faceboo
Whom may we thank for refer	ring you to our pract	tice?			
In an emergency who should be notified?			Phone:		



Information Sharing consent Form

ı	give permission to share information concerning
0	My dental diagnosis and recommended treatment
0	The cost and financial arrangements for my treatment
0	My personal health information
0	Other
l give	my permission to share the above noted information with:
0	My spouse (name)
0	My parents (name)
0	My adult child or children (name)
0	Other
l.	DO NOT give permission to share ANY
	nation regarding my treatment, financial arrangements or personal health information
	the exception of what is outlined in the Mountain View Dental HIPPA policy.
Sign:_	Date:
Data A.	D. L.

MEDICAL HISTORY

PATIENT NAME		Birth Date				
Although dental personnel primarily to have, or medication that you may be following questions.	reat the area in and around your taking, could have an important i	mouth, your mouth is a pa interrelationship with the de	rt of your entire body. He entistry you will receive.	ealth problems that you may Thank you for answering the		
Do you use con	a major operation? Yes lead or neck injury? Ye	No If yes, please explain No If yes, please explain No If yes, please explain No No No No No				
Pregnant/Trying to get pregnant?		traceptives? Yes N	o Nursing? Ye	s No		
Aspirin Peniciflin	Codeine Local Anes	- '	c Metal	Latex Sulfa drugs		
AIDS/HIV Positive Alzheimer's Disease Anaphylaxis Anemia Arthritis/Gout Arthritis/Gout Arthritical Joint Asthma Blood Disease Blood Transfusion Breathing Problem Bruise Easily Cancer Chemotherapy Chest Pains Conyenital Heart Disorder Convulsions Pave you ever had any serious illnes AIDS/HIV Positive Yes No N	Cortisone Medicine Diabetes Drug Addiction Easily Winded Emphysema Epilepsy or Seizures Excessive Bleeding Excessive Thirst Fainting Spells/Dizziness Frequent Cough Frequent Diarrhea Frequent Diarrhea Frequent Headaches Genital Herpes Glaucoma Hay Fever Heart Attack/Failure Heart Murmur Heart Pacemaker Heart Trouble/Disease Yes Ves Yes Heart Trouble/Disease Yes	No Hemophilia Hepatitis A Hepatitis B or C Herpes No High Blood Pressure High Cholesterol Hives or Rash Hypoglycemia Irregular Heartbeat Kidney Problems Leukemia Liver Disease No Mitral Valve Prolaps No Osteoporosis No Pain in Jaw Joints Parathyroid Disease No No Psychiatric Care	Yes No Recent Renal Rheum Rheu	Rever Yes No Cell Disease Yes No Trouble Yes No Brida Yes No Ch/Intestinal Disease Yes No In g of Limbs Yes No Id Disease Yes No Id Diseas		
Comments						
To the best of my knowledge, the que dangerous to my (or patient's) healt	uestions on this form have been a h. It is my responsibility to inform	accurately answered. I und	derstand that providing in hanges in medical status	correct information can be		
SIGNATURE OF PATIENT, PAREN	T, or GUARDIAN		DA	TE		