ARBOR DENTAL GROUP

3151 So. White Road, Suite 104 • San Jose, California 95148 • Tel. (408) 270-2273

We are complimented that you have selected us to provide dental care for you and your family.

Whom may we thank for referring you to our office?

	Patier	nt information —				
Date — Patient's Name — —	Last	Firs	t	Middle		
Address						
Street Home Ph # () Cell Ph # ()	Work Ph # (City Soc Sec		Zip Drivers Lic #		
Birthday / / If patient is a minor, gir						
If patient is a full-time student fill in school name			1.0. 1.1			
Name of nearest relative not living with you		DI	H /			
Complete address Emergency Contact		_	, ,			
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	- Responsi	ble Party Information				
Name		SSN	D.O.B			
Home Address						
Home Phone		City	State Cell Phone	Zip		
Employed by	Occupation		Email:			
Dental Insurance Company			Group No			
Address			Phone			
Spouse name		SSN	D.O.B.			
Home Address if different		City				
Home Phone	Work Phone	City		Zip		
Employed by			Email:			
Dental Insurance Company			Group No			
Address			Phone			
	Den	tal Information				
Do your gums bleed when you brush? Yes	No _					
, ,			No Swe	eets Yes No		
•						
, ,						
Date of Last dental examination			time ?			
Former Dentist Name	City					
How would you describe your current dental prob	olem ?					
How do you feel about the appearance of your te	eth?					

2. Helse you be seen a patient in the hospital during the past two years? 2. Helse you be seen a patient in the hospital during the past two years including appetite suppressants. 4. Helse you taken any medication of drugs 4? 4. Helse you taken any medication of drugs during the past two years including appetite suppressants. Femchere infentiormine & printment or definitioration of control during the past two years including appetite suppressants. Femchere infentiormine & printment or definitioration or of the definition of control during the past two years or since taking any of the appetite suppressants named above? 7. Here you been under the case of medical doctor during the past two years or since taking any of the appetite suppressants named above? 7. Here you been under the case of medical doctor during the past two years or since taking any of the appetite suppressants named above? 7. Here you been under the case of medical doctor during the past two years or since taking any of the appetite suppressants named above? 7. Here you been under the case of medical doctor during the past two years or since taking any of the appetite suppressants named above? 7. Here you been under the case of medical doctor during the past two years or since taking any of the appetite suppressants named above? 7. Here you been under the case of medical doctor during the past two years or since taking any of the appetite suppressants named above? 7. Here you been under the case of medical doctor during the past two years or since taking any of the appetite suppressants named above? 7. Here you been under the case of medical doctor during the past two years or since taking appetite suppressants named above? 7. Here you been under the case of medical doctor during the past two years or since taking appetite suppressants named above? 7. Here you been under the suppressants named above? 7. Here you been under the during appetite only the past two years on the past two years or the past two years on the past two years or			Medical Intol	rmation				
2. Have you been a patent in the hospital during the past two years 7	Are you having pain or discomfort at this ti	me ?					YES	NO
Hyee, please liet. A leve you taken any medication of drugs during the past two years including appetite suppressants. Feur-pharn (fenturamine & phenthermine) or dederfuluramine or fenturamine? YES NO	2. Have you been a patient in the hospital during the past two years?						YES	NO
4. Have you taken any medication of drugs during the past two years including apporties suppressants - fenr-phen (inclusiones 2 phenintermine) or destinationaries or fenrinamentee? YES NO Physician's Name Phone No ()		s?					YES	NO
or dedenfuramine or fanfuramenie? Five you been under the care of medical doctor during the past two years or since taking any of the appetite suppressants named above? Physician's Name Phone No () **Physician's Name Address** **Phone No () **Indicate which of the following you have tad or have present. Circle "YES" or "NO" to each term. **Do you snote or allergic to any medication or aneesthetics? **Indicate which of the following you have tad or have present. Circle "YES" or "NO" to each term. **Do you snote or "YES" NO Address.** **PES NO Thyroid poolenes.** **PES NO Congenital Man Disease.** **PES NO Address.** **PES NO Congenital Man Disease.** **PES NO Thyroid poolenes.** **PES NO Congenital Man Disease.** **PES NO Address.** **PES NO Congenital Man Disease.** **PES NO Theoreticals.** **PES N		ring the past two	vears including annetite	sunnressants -	fen-nhen	(fenluramine & phenthermine)		
Physician's Name Address 6. Are you sensitive or altergic to any medication or anesthetics? If yes, please list. Indicate which of the following you have had or have present. Circle "YES" or "NO" to each item. Do you smoke?							YES	NO
6. Are you sensitive or allergic to any medication or anesthetics? If yee, please list Indicate which of the following you have had or have present. Circle "VES" or "NO" to each item. Do you smoke? YES NO Allergy to latav. YES NO Heart Failure YES NO Afficial Joints (his, hase exc) YES NO Allergy to Metal Joints (his, hase exc) YES NO Allergy to Metal Joints (his, hase exc) YES NO Allergy to Metal Joints (his, hase exc) YES NO Allergy to Metal Joints (his, hase exc) YES NO Allergy to Metal Joints (his, hase exc) YES NO Allergy to Metal Joints (his, hase exc) YES NO Allergy to Metal Joints (his, hase exc) YES NO Allergy to Metal Joints (his, hase exc) YES NO Allergy to Metal Joints (his, hase exc) YES NO Allergy to Metal Joints (his, hase exc) YES NO Allergy to Metal Joints (his, hase exc) YES NO Allergy to Metal Joints (his, hase exc) YES NO Allergy to Metal Joints (his, hase exc) YES NO Heart Murrur YES NO Heart Murrur YES NO Allergy to Metal Joints (his, hase exc) YES NO Heart Murrur YES NO Allerges (his No Heart Murrur YES NO Heart Murrur YES NO Allerges (his No Heart Murrur YES NO Mind Vive Prolapses YES NO Allerges (his No Heart No Allergy to Metal Joints (his No Allerges (his No Heart No Allergy to Metal Joints (his No Heart No Allerges (his No Heart No Allerges (his No Heart No Heart No Allerges (his No Heart No Heart No Heart No Allerges (his No Heart No	5. Have you been under the care of medical doctor during the past two years or since taking any of the appetite suppressants named above?							
6. Are you sensitive or allergic to any medication or anesthelics? 7. Indicate which of the following you have had or have present. Circle "YES" or "NO" to each item. Do you smoke? YES NO Sickle Call Disease YES NO Allergy to latex. PS NO Allergy to latex. YES NO Heart Fallure. YES NO Allergy to latex. YES NO Heart Fallure. YES NO Heart Fallure. YES NO Heart Seases or Attack. YES NO Heart Seases or Attack. YES NO Ucors YES NO Heaptile Serum YES NO Congenital heart Disease or YES NO Ucors YES NO Heaptile Serum YES NO Congenital heart Disease. YES NO Diseases YES NO Diseases. YES NO Heart Murrur. YES NO Thyroid problems YES NO HIP Positive PES NO Heart Murrur. YES NO Thyroid problems YES NO HIP Positive PES NO Heart Murrur. YES NO Thyroid problems YES NO HIP Positive PES NO Cod SoresFeve Blisters YES NO Area. Arteriosclerosia. YES NO Concer. YES NO Horring Cough YES NO Heart Murrur. YES NO Throid Cough YES NO Horring Cough YES NO Heart Murrur. YES NO Throid Cough YES NO Heart Murrur. YES NO Heart Sease YES NO Emphysema. YES NO Heart Sease YES NO Heart Wale. YES NO Throid Cough YES NO Area. Arteriosclerosia. YES NO Area. YES NO Area. YES NO Heart Wale. YES NO Tuberclocks. YES NO Area. YES NO Heart Wale. YES NO Horring Cough YES NO Area. Heart Surgery. YES NO Arteria. YES NO Heart Wale. YES NO Horring Cough YES NO Heart Wale. YES NO Positive YES NO Positive Wale. YES NO Heart Wale.				PI	none No ()	_	
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Afthritis — YES NO Allergies or Hives — YES NO Epilepsy or Seizures — YES NO Remembratism — YES NO Sinus Trouble — YES NO Preserves — YES NO Remembratism — YES NO Rediction — YES NO Report — YES NO Nervousness — YES NO Drug Addiction — YES NO Preserves — YES NO Developmentally Disabled — YES NO Stroke — YES NO Hepatitis A (infectious) — YES NO Developmentally Disabled — YES NO Stroke — YES NO Developmentally Disabled — YES NO Developmentally Disabled — YES NO Popur ankles swell during the day? — YES NO Popur ankles swell during the day? — YES NO Popur ankles swell during the day? — YES NO Popur ankles swell during the day? — YES NO Popur ankles swell during the day? — YES NO Popur ankles swell during the day? — YES NO Popur ankles swell during the day? — YES NO Popur ankles swell during the day? — YES NO Popur ankles swell during the day? — YES NO Popur ankles swell during the day? — YES NO Popur ankles swell during the day? — YES NO Popur ankles swell during the day? — YES NO Popur ankles swell during the day? — YES NO Popur ankles swell during the day? — YES NO Popur ankles swell during the day? — YES NO Popur ankles swell during the day? — YES NO Popur ankles part of the part of	Heart Surgery YES				NO			NO
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Cortisone Medicine ——YES NO Radiation Therapy ——YES NO Nervousness — YES NO Drumors ——YES NO Drumors ————————————————————————————————————			•					
Drug Addiction								
Stroke							_	
8. 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? 9. Do your ankles swell during the day? 10. Do you use more than two pillows to sleep ? 11. Have you lost or gained more than 10 pounds in the past year? 12. Do you ever wake up from sleep and feel short of breath? 13. Are you on a special diet? 14. Do you have or have you had any disease, condition or problem not listed above? 15. Do you never wake up from sleep and feel short of breath? 16. Do you have or have you had any disease, condition or problem not listed above? 17. Experiments of the state of								
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12. Do you ever wake up from sleep and feel short of breath? YES NO 13. Are you on a special diet? YES NO 14. Do you have or have you had any disease, condition or problem not listed above? YES NO 15. Do you need to be premedicated prior to dental treatment? YES NO 16. Type Please list: 17. Do you need to be premedicated prior to dental treatment? YES NO 17. Are you pregnant? Yes, what month? Yes No 18. Are you nursing, Yes No Are you taking birth control pills? Yes No 19. No 19. No Are you nursing New Yes No Are you taking birth control pills? Yes No 19. No 19. No Are you nursing New Yes No Are you taking birth control pills? Yes No 19. No 19. Patient signature Date CONSENT: 10. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aide deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs. 19. Is also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) 10. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment. 19. I understand that all responsibility of payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates. I understand that a 1-1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges. 19. Lunderstand that where appropriate, credit bureau reports may be obtained. 20. Lunderstand that where appropriate, credit bureau reports may be obtained. 31. Lunderstand that where appropriate, credit bureau reports may be obtained. 42. Lunderstand that where appropriate, credit bureau reports may be obtained. 43. Lunderstand t								
13. Are you on a special diet? 14. Do you have or have you had any disease, condition or problem not listed above?								
14. Do you have or have you had any disease, condition or problem not listed above? If yes Please list: 15. Do you need to be premedicated prior to dental treatment? FOR WOMEN ONLY: Are you pregnant? Yes, what month? Are you nursing, Yes No Are you taking birth control pills? Yes No I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions truthfully and to the best of my knowledge. Patient signature Date CONSENT: 1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aide deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs. 2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient). I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment. 3. I understand that all responsibility of payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates. I understand that a 1-1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges. 4. I understand that where appropriate, credit bureau reports may be obtained. 5. I understand that where appropriate, credit bureau reports may be obtained. 6. I understand that it is my responsibility to advise your office of any changes in the information contained in this form. Patient Date Witness Relationship to Patient								
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15. Do you need to be premedicated prior to dental treatment?		s, condition or pro	bbletii iiot iisted above ! _				ILS	NO
FOR WOMEN ONLY: Are you pregnant? Yes, what month? Are you nursing, Yes No Are you taking birth control pills? Yes No I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions truthfully and to the best of my knowledge. Patient signature Date Date CONSENT: 1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aide deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs. 2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment. 3. I understand that all responsibility of payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendere unless other arrangements have been made. In the event payments are not received by the agreed upon dates. I understand that a 1-1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges. 4. I understand that where appropriate, credit bureau reports may be obtained. 5. I understand that where appropriate, credit bureau reports may be obtained. Patient Date Witness Parent or Responsible Party Relationship to Patient Relationship to Patient	15. Do you need to be premedicated prior to o	dental treatment?	?				YES	NO
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CONSENT: 1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aide deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs. 2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment. 3. I understand that all responsibility of payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are renderer unless other arrangements have been made. In the event payments are not received by the agreed upon dates. I understand that a 1-1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges. 4. I understand that where appropriate, credit bureau reports may be obtained. 5. I understand that it is my responsibility to advise your office of any changes in the information contained in this form. Patient Date Witness Parent or Responsible Party Relationship to Patient	Patient signature			Data				
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