SHLASH ORTHODONTICS

ADULT

DALIA SHLASH DDS MPH **RICHARD MATTSON** DMD PA

Patient Name:_____ Gender:_____ Birthdate: ____/____/_____

Address: _____

City: _____ State: _____ Zip Code: _____ Marital Status: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

Occupation: _____

Employer: _____

General Dentist: _____ Last Visit: _____

Family Members Treated in our office?

PRIMARY DENTAL INSURANCE COVERAGE

Orthodontic coverage? Yes _____ No _____

Policy Holder Name: _____ Birthdate: _____/_____/_____

Policy Holder Employer: _____

Dental Ins. Co. Name: _____

Address: _____

Phone: _____ Group #: _____ Insurance ID# or SS#: _____

Do you have any of the following?

Y	N	Heart Disease	Y	N	HIV or AIDS	Other:	_____
Y	N	Tuberculosis	Y	N	Cancer		_____
Y	N	Kidney Disease	Y	N	Stroke		_____
Y	N	High Blood Pressure	Y	N	Abnormal Bleeding		_____
Y	N	Hepatitis	Y	N	Allergy to any Drugs	Please list all medications:	_____
Y	N	Rheumatic Fever	Y	N	Clicking Jaw Joints		_____
Y	N	Heart Murmur	Y	N	Frequent Headaches		_____
Y	N	Diabetes	Y	N	Grinding/Clenching Teeth		_____
Y	N	Epilepsy	Y	N	Pain in the Jaw Joints		_____

Y N Dialysis/Transplant/Hospitalizations _____

_____

_____

Physician Name: _____

SIGNATURE OF PATIENT: _____ DATE: _____