

James W. Seyfried, DDS 1624 Library Lane Minden, NV 89423

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Patient's Name:	Male Female DOB:			
Mailing Address (including Street, City, S				
SSN:	Phone Number:			
Employer:	Occupation:			
Cell Phone:	Work Phone:			
Full Name of Spouse, if applicable:	Email:			
Who may we thank for referring you?				
Person to contact in case of emergency: _	Phone: ()			
Dental Insurance? No□ Yes □ (If yes, Please	e complete the following information and present your card to Receptionist)			
Insurance Company Name:	Company Phone:			
Address:				
Subscriber's Name:	Relationship to Patient:			
DOB: SSN or ID	Number: Group Number:			
Secondary Dental Insurance? No 🗆 Yes	$s \square$ (If yes, Please complete the following information)			
Subscriber's Name:	#2 Insurance Company Name:			
Company Phone:				
Address:	DOB:			
SSN or ID Number:	Group Number:			
	Consent			
patient's dental needs. I also authorize the Doctor to perform are ther authorize and consent that Doctor choose and employ such the responsibility for payment (for dental services provided in the revious arrangements have been made. I the undersigned, have record, I will so inform this praction of the provided in the process of the provided in the revious arrangements have been made. I the undersigned, have record, I will so inform this praction.	, study models, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the ny and all forms of treatment, medication, and therapy, that may be indicated in connection with this patient, and h assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand is office for myself or my dependents) is mine, and is due and payable at the time services are rendered, unless re given the above information, have reviewed it and find it accurate. If there are any later changes to this history ce. I hereby authorize necessary credit information to be obtained by your office. **Insurance Portability and Accountability Act**			
I have been informed/receive	ed a copy of the Notice of Privacy Practices for Protected Health Information. Beginning to the Notice of Privacy Practices for Protected Health Information. Beginning to the Notice of Privacy Practices for Protected Health Information. Beginning to the Notice of Privacy Practices for Protected Health Information. Beginning to the Notice of Privacy Practices for Protected Health Information. Beginning to the Notice of Privacy Practices for Protected Health Information. Beginning to the Notice of Privacy Practices for Protected Health Information. Beginning to the Notice of Privacy Practices for Protected Health Information. Beginning to the Notice of Privacy Practices for Protected Health Information. Beginning to the Notice of Privacy Practices for Protected Health Information. Beginning to the Notice of Privacy Practices for Protected Health Information. Beginning to the Notice of Privacy Practices for Protected Health Information. Beginning to the Notice of Privacy Practices for Protected Health Information. Beginning to the Notice of Privacy Practices for Protected Health Information. Beginning to the Notice of Privacy Practices for Protected Health Information. Beginning to the Notice of Privacy Practices for Protected Health Information. Beginning to the Notice of Privacy Practices for Protected Health Information. Beginning to the Notice of Privacy Practices for Protected Health Information. Beginning to the Notice of Privacy Practices for Protected Health Information. Beginning to the Notice of Privacy Practices for Protected Health Information. Beginning to the Notice of Privacy Practices for Protected Health Information. Beginning to the Notice of Privacy Practices for Protected Health Information. Beginning to the Notice of Privacy Practices for Protected Health Information. Beginning to the Notice of Privacy Practices for Protected Health Information. Beginning to the Notice of Privacy Practices for Protected Health Information. Beginning to the Notice of Privacy Practices f			

Medical Information

Date of last medical exam:	Name of Physician:	City:		Phone:			
Do you have current medical problems? No Yes If yes, please state: Have you ever had or do you have any of the following? (Please circle any that apply)	Date of last medical exam:	Are yo	ou pregnant? No	☐ Yes ☐ Due:			
Liver Disease Liver Disease Liver Disease Arthritis Disease Arthritis Disease Arthritis Disease Arthritis Disease Arthritis Disease Arthritis Disease Dise							
Liver Disease Jaundice Fainting spells/ Epilepsy/ Convulsions/ Dizziness Nervous Breakdown X-ray/ Indium or Cobalt treatment High Blood Pressure Heart Problems, type: Heart Problems, type: Heart Problems, type: Heart Murmur HIV Infection Shortness of Breath Stroke, when: Stroke, when: Stroke, when: Head Injury Allergy/Hay Fever Glaucoma Sinus Bone loss and taking Bisphosphonate Drugs Blood Trouble/Anemia/Leukemia Allergy/Hay Fever Glaucoma Sinus Bone loss and taking Bisphosphonate Drugs History of Drug Dependency? OTHER: Are you now taking medicines for: (please specify medication) Pain Heart Headaches Sleeping Arthritis Blood (thinners, other) Stomach OTHER: Have you ever shown an allergy to, been sick from, or been told not to take: Antibiotics: Anesthetic: OTHER: Have you ever shown an allergy to, been sick from, or been told not to take: Antibiotics: Anesthetic: Do you have any disease, condition, or problem that is not mentioned above? Dental History Reason for this visit Previous Dentist: Date of Last dental x-rays Have you ever had orthodontic treatment? Have you ever had periodontal (gum) surgery? Have you over had periodontal (gum) surgery? Have you over had periodontal (gum) surgery? Have you over had periodontal (gum) surgery? Have you noticed any loosening of your teeth? Previous cliench or grind your teeth while asleep or awake? Po you layen has above information, have reviewed it and find it accurate. If there are any later changes, I will so inform this practice.							
Fainting spells/ Epilepsy/ Convulsions/ Dizziness	Hepatitis Lung Trouble/As						
Diabetes High Blood Pressure High Blood Pressure Heart Murmur Heart Murmur Heart Murmur Horisetion Shortness of Breath Stroke, when: Blood Trouble/Anemia/Leukemia Autoimmune Disease Stroke, when: Blood Trouble/Anemia/Leukemia Altergy/Hay Fever Glaucoma Sinus Bone loss and taking Bisphosphonate Drugs Bone loss and taking Bisphosphonate Drugs History of Drug Dependency? OTHER: Are you now taking medicines for: (please specify medication) Pain Heart Heart Headaches Sleeping Arthritis Blood (thinners, other) Allergy Stomach Birth Control OTHER: Have you ever shown an allergy to, been sick from, or been told not to take: Antibiotics: Antibiotics: Anesthetic: Anesthetic: Anesthetic: Apprint Have you been told you need to PREMEDICATE before dental appointments by a doctor? Do you have any disease, condition, or problem that is not mentioned above? Dental History Beason for this visit Previous Dentist: Date last treated: Date of Last dental X-rays Have you ever had onthodontic treatment? Have you ever had periodontal (gum) surgery? Have you ever had proidontal (gum							
High Blood Pressure Heart Problems, type:		Nervous Breakdo					
Heart Murmur HIV Infection Stroke, when: Str	Diabetes	•					
Heart Murmur Shortness of Breath Stroke, when: Stroke, when: Stroke, when							
Shortness of Breath Stroke, when: Kidney Disease Kidney Disease Kidney Disease Head Injury Allergy/Hay Fever Glaucoma Sinus Bone loss and taking Bisphosphonate Drugs History of Drug Dependency? OTHER: Are you now taking medicines for: (please specify medication) Pain				Replacement			
Stroke, when:				2222			
Blood Trouble/Anemia/Leukemia Allergy/Hay Fever Glaucoma Sinus Bone loss and taking Bisphosphonate Drugs Do you use street drugs: History of Drug Dependency? OTHER: History of Drug Dependency? OTHER: Heart Nerves Headaches Sleeping Arthritis Blood (thinners, other) Allergy Stomach Birth Control OTHER: Have you ever shown an allergy to, been sick from, or been told not to take: Antibiotics: Anesthetic: Other medications: Aspirin Latex Allergy Have you been told you need to PREMEDICATE before dental appointments by a doctor? Do you have any disease, condition, or problem that is not mentioned above? Dental History Reason for this visit Previous Dentist: Date of Last dental x-rays Have you ever had orthodontic treatment? Yes No Have you ever had periodontal (gum) surgery? Yes No Have you ever had periodontal (gum) surgery? Yes No Have you ever had periodontal (gum) surgery? Yes No Have you ever had periodontal (gum) surgery? Yes No Have you ever had periodontal (gum) surgery? Yes No Have you ever had periodontal (gum) surgery? Yes No Have you ever had periodontal (gum) surgery? Yes No Have you ever had periodontal (gum) surgery? Yes No Have you ever had periodontal (gum) surgery? Yes No Have you ever had periodontal (gum) surgery? Yes No Have you ever had periodontal (gum) surgery? Yes No Have you ever had periodontal fum) surgery? Yes No Have you ever had periodontal fum the youn you teeth? Yes No Have you ever had ental extractions? Yes No Have you				ase			
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Sinus Do you use street drugs:							
OTHER: Are you now taking medicines for: (please specify medication) Pain				aking Risphosphonate Drugs			
Are you now taking medicines for: (please specify medication) Pain							
Are you now taking medicines for: (please specify medication) Pain			, Dependency:				
Pain							
Nerves Sleeping	•						
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Blood (thinners, other) Stomach Thyroid Birth Control OTHER: Have you ever shown an allergy to, been sick from, or been told not to take: Antibiotics: Antibiot	Nerves Headaches Headaches						
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	Signature		Date				