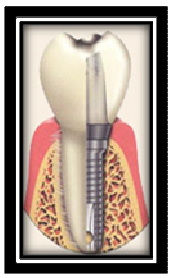

C & E Elite Family Dentistry, SC

"Experts in Creating Healthy Attractive Smiles"

7155 N. Port Washington Rd. – Milwaukee, WI 53217

(414) 531-3482

Drs. Ellie & Carlos Parajon are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date_____ **Home Phone** (_____)_____ **Cell Phone** (_____)_____

Name_____ **SS#/Patient ID#**_____

Address_____

City_____State_____Zip_____Sex ___M ___F Age_____ Birthdate _____

____ Married ____Widowed ____Single ____Minor ____Separated ____Divorced

Patient employer/School_____Occupation_____

Employer/School address_____Employer/school phone (____)_____

Whom may we Thank for referring you?_____

E-Mail_____

In case of **Emergency** who should be notified? _____**Emergency Phone** (____)_____

Primary Insurance

Person Responsible for Account_____

Relation to Patient_____ Birthday _____ SS#_____

Address_____ Phone (____)_____

City_____ State_____ Zip_____

Person responsible Employed by_____Occupation_____

Business Address_____Business Phone (_____)_____

Insurance Company_____

Contract #_____ **Group#**_____ **Subscriber #**_____

Dental History

Reason for Today's Visit_____

Date of last dental care_____ Date of Last dental _____

Former Dentist_____

Address_____

Check ☑ if you have had problems with any of the following:

__Bad breath	__Grinding teeth	__Sensitivity to hot	__Bleeding gums
__Loose teeth or broken fillings	__Sensitivity to sweets	__Clicking or popping Jaw	__Periodontal treatment
__Sensitivity when biting	__Food collection b/w teeth	__Sensitivity to cold	__Sores in your mouth

Medical History

Physician's Name_____ date of last visit_____

Have you ever taken any of the group drugs collectively referred to as **"fen-phen?"** These include combinations of lonimin, adipex, fastin (brand names of phentermine), pondimin (fenfluramine), and redux (dexfenfluramine). ____Yes ____No

Have you had any serious illnesses or operations? ____Yes ____No

If Yes,
describe_____

Have you ever had a blood transfusion? ____Yes ____No If Yes, give approximate dates_____

(Women) are you Pregnant? ____ Yes ____No Nursing? ____Yes ____No Taking birth control pills? ____Yes ____no

Check ☑ if you have had problems with any of the following:

____Anemia	____Cortisone Treatments	____Hepatitis	____Scalet Fever
____Arthritis	____Cough, Persistent	____High Blood Pressure	____Shortness of Breath
____Artificial Heart Valves	____Cough up blood	____HIV/AIDS	____Skin Rash
____Artificial Joints	____Diabetes	____Jaw Pain	____Stroke
____Asthma	____Epilepsy	____Kidney Disease	____Swelling of feet or ankles
____Back Problems	____Fainting	____Liver Disease	____Thyroid problems
____Blood Disease	____Glaucoma	____Mitral Valve Prolapse	____Tobacco Habit
____Cancer	____Headaches	____Pacemaker	____Tonsillitis
____Chemical Dependency	____Heart Murmur	____Radiation Therapy	____Tuberculosis
____Chemotherapy	____Heart problems	____Respiratory Disease	____Ulcer
____Circulatory Problems	____Hemophilia	____Rheumatic fever	____Venereal Disease

Medications: List medications you are currently taking: _____ _____

_____ _____ _____

_____ _____ _____

Allergies:_____

Authorization

I certify that I, and/or dependent(s), have insurance coverage with (Insurance Name) _____ and assign directly to Drs. C & E Parajon all insurance benefits, if any, otherwise payable to me fo services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist(s) may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Payment is due in Full at Time Of Treatment unless prior arrangements have been made

Signature of Patient, Parent, Guardian or Personal Representative_____Date_____

Please print name of patient, Parent, Guardian or Personal Representative_____Relationship to Patient_____