Gary S. Hongo, DMD 9732 SE WASHINGTON STREET, SUITE H, PORTLAND, OR 97216

PATIENT:	(LAST)		(FIRST)		(M.I.)
Sex F M	Marital Status	Birthday	SS#		
Phone: Home	Work	Ext	Cell		
RESPONSIBLE PAR	RTY (if patient under 18)	(LAST)		(FIRST)	(M.I.)
Sex F M	Marital Status	Birthday	SS#		
Address:		City		State	Zip Code
E-Mail:					
Phone: Home	Work	Ext	Cell		
EMERGENCY (CONTACT:	MUST E	BE FILLED OUT		
Name:			Rel	ationship to pati	ent
Home Phone:_		Work Phone	:		
How else were you DENTAL INSU	referred to our office?RANCE		DENTAL HISTOR	Υ	
DENTAL INSU	RANCE		DENTAL HISTOR	Υ	
D	DENTAL PRIMARY CARR	IFD	Danam Cantadan's misit		
Employee's Nan	ne:		Previous dentist's name	:	
Employee's Nan Date of Birth:	me:SS#		Previous dentist's name City/State:	:	Phone:
Employee's Nan Date of Birth: Employer:	me:SS#		Previous dentist's name City/State: Date last treated:	:	Phone: Last X-ray date:
Employee's Nan Date of Birth: Employer: Insurance Co. N	ss#ss#		Previous dentist's name City/State: Date last treated: (Please check if YE	EScomment sp	_ Phone: _ Last X-ray date: ace below)
Employee's Nan Date of Birth: Employer: Insurance Co. N Address:	ss#ss#		Previous dentist's name City/State: Date last treated: (Please check if YE) Orthodontic Treatment	EScomment sp	_ Phone: Last X-ray date: ace below) Year:
Employee's Nan Date of Birth: Employer: Insurance Co. N Address: Phone:	ss#ss#		Previous dentist's name City/State: Date last treated: (Please check if YE Orthodontic Treatme Oral Surgery? (Extra Periodontal (Gum)	EScomment spent? (Braces)	_ Phone: Last X-ray date: ace below) Year: Year: Year:
Employee's Nan Date of Birth: Employer: Insurance Co. N Address: Phone: Group/Local#:	SS#Same:		Previous dentist's name City/State: Date last treated: (Please check if YE Orthodontic Treatme Oral Surgery? (Extra Periodontal (Gum) To Your bite adjusted?	EScomment sp ent? (Braces) actions) Freatment?	_ Phone: Last X-ray date: ace below) Year: Year:
Employee's Nan Date of Birth: Employer: Insurance Co. N Address: Phone: Group/Local#:	ss#ss#		Previous dentist's name City/State: Date last treated: (Please check if YE Orthodontic Treatme Oral Surgery? (Extra Periodontal (Gum)	EScomment sp ent? (Braces) actions) Freatment?	_ Phone: Last X-ray date: ace below) Year: Year: Year: Year:
Employee's Nan Date of Birth: Employer: Insurance Co. N Address: Phone: Group/Local#: Insured's Relation	SS#Same:		Previous dentist's name City/State: Date last treated: (Please check if YE Orthodontic Treatme Oral Surgery? (Extra Periodontal (Gum) T Your bite adjusted? Are any teeth loose?	EScomment spent? (Braces) actions) Freatment?	_ Phone: Last X-ray date: ace below) Year: Year: Year: Year:
Employee's Nam Date of Birth: Employer: Insurance Co. N Address: Phone: Group/Local#: Insured's Relation	SS# fame: conship to patient: CNTAL SECONDARY CAR	RRIER	Previous dentist's name City/State: Date last treated: (Please check if YE Orthodontic Treatme Oral Surgery? (Extra Periodontal (Gum) To Your bite adjusted? Are any teeth loose? Does food get caught JAW PROBLEMS Pain (joint, ear, side	EScomment sp ent? (Braces) actions) Greatment? at between your teef	_ Phone: Last X-ray date: ace below) Year: Year: Year: Year: h? Difficulty chewing?
Employee's Nan Date of Birth: Employer: Insurance Co. N Address: Phone: Group/Local#: Insured's Relation DE Employee's Nan	ss# same: conship to patient: contact SECONDARY CAR me:	RRIER	Previous dentist's name City/State: Date last treated: (Please check if YE Orthodontic Treatme Oral Surgery? (Extra Periodontal (Gum) To Your bite adjusted? Are any teeth loose? Does food get caugh JAW PROBLEMS Pain (joint, ear, side Difficulty opening &	EScomment spent? (Braces) actions) Treatment? It between your teet of face)?	_ Phone: Last X-ray date: ace below) Year: Year: Year: Year: Year:
Employee's Nam Date of Birth: Employer: Insurance Co. N Address: Phone: Group/Local#: Insured's Relation DE Employee's Nam Date of Birth:	ss#	RRIER	Previous dentist's name City/State: Date last treated: (Please check if YE Orthodontic Treatme Oral Surgery? (Extra Periodontal (Gum) To Your bite adjusted? Are any teeth loose? Does food get caught JAW PROBLEMS Pain (joint, ear, side Difficulty opening & HABITS: DO YOU	EScomment sp ent? (Braces) actions) Freatment? at between your teet of face)? at closing?	_ Phone: Last X-ray date: **ace below*) Year: Year: Year: Year: Tear: Clicking of jaw?
Employee's Nam Date of Birth: Employer: Insurance Co. N Address: Phone: Group/Local#: Insured's Relation DE Employee's Nam Date of Birth: Employer:	ss#ss#sme:ss#sme:sss#sme:sss#ssss*sss*ssss*ssss*ssss*ssss*ssss*ssss*ssss*sss*ssss*ssss*sss*ssss*ssss*ssss*ssss*ssss*	RRIER	Previous dentist's name City/State: Date last treated: (Please check if YE Orthodontic Treatme Oral Surgery? (Extra Periodontal (Gum) To Your bite adjusted? Are any teeth loose? Does food get caught JAW PROBLEMS Pain (joint, ear, side Difficulty opening & HABITS: DO YO Clench or grind you Bite your lips or che	EScomment spent? (Braces) actions) Freatment? It between your teet of face)? It closing? U It teeth while awake eks regularly?	_ Phone: Last X-ray date: ace below) Year: Year: Year: Year: h? Difficulty chewing? Clicking of jaw? or asleep?
Employee's Nam Date of Birth: Employer: Insurance Co. N Address: Phone: Group/Local#: Insured's Relation DE Employee's Nam Date of Birth: Employer: Insurance Co. N	ss#ss#ssme:ss#ss#sme:ss#sme:ss#sme:ss#same:	RRIER	Previous dentist's name City/State: Date last treated: (Please check if YE Orthodontic Treatme Oral Surgery? (Extra Periodontal (Gum) T Your bite adjusted? Are any teeth loose? Does food get caught JAW PROBLEMS Pain (joint, ear, side Difficulty opening & HABITS: DO YO Clench or grind you Bite your lips or che Hold foreign objects	EScomment spent? (Braces) actions) Freatment? It between your teet of face)? to closing? U r teeth while awake eks regularly? with your teeth? (p	_ Phone: Last X-ray date: ace below) Year: Year: Year: Year: Th? Difficulty chewing? Clicking of jaw? or asleep? encils, pins, nails, fingernails
Employee's Nam Date of Birth: Employer: Insurance Co. N Address: Phone: Group/Local#: Insured's Relation DE Employee's Nam Date of Birth: Employer: Insurance Co. N Address:	same:SS#same:SS#same:SS#same:SS#same:SS#same:SS#same:SS#same:SS#same:SS#same:SS#	RRIER	Previous dentist's name City/State: Date last treated: (Please check if YE Orthodontic Treatme Oral Surgery? (Extra Periodontal (Gum) To Your bite adjusted? Are any teeth loose? Does food get caugh JAW PROBLEMS Pain (joint, ear, side Difficulty opening & HABITS: DO YO Clench or grind you Bite your lips or che Hold foreign objects Children: Dental dev Is it important to you	EScomment spent? (Braces) actions) Freatment? It between your teet of face)? It closing? U It teeth while awake eks regularly? It with your teeth? (pyelopment concerns a to keep your teeth	Phone: Last X-ray date: ace below) Year: Year: Year: Year: h? Difficulty chewing? □ Clicking of jaw? or asleep? encils, pins, nails, fingernails? ?
Employee's Nam Date of Birth: Employer: Insurance Co. N Address: Phone: Group/Local#: Insured's Relation DE Employee's Nam Date of Birth: Employer: Insurance Co. N Address: Phone:	ss#ss#ssme:ss#ss#sme:ss#sme:ss#sme:ss#same:	RRIER	Previous dentist's name City/State: Date last treated: (Please check if YE Orthodontic Treatme Oral Surgery? (Extra Periodontal (Gum) T Your bite adjusted? Are any teeth loose? Does food get caugh JAW PROBLEMS Pain (joint, ear, side Difficulty opening & HABITS: DO YO Clench or grind you Bite your lips or che Hold foreign objects Children: Dental dev	EScomment spent? (Braces) actions) Greatment? It between your teef Conface)? Colosing? U It teeth while awake eks regularly? So with your teeth? (pyelopment concerns to keep your teeth the appearance of the spearance of	Year: Year: Year: Year: h? Difficulty chewing? Clicking of jaw? or asleep? encils, pins, nails, fingernails? ? Syour teeth?

Date

Signature_