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	s No	Hay Fever						No
		Latex Sensitivity.						No
Yes		Allergies or Hives						No
Yes		Sinus Trouble						No
ed)Yes	s No	Radiation Therapy						No
nee, etc.) Yes	s No				Nervous/Anxious		Yes	No
Yes	s No	Tumors	Y	es No				No
an two nillows to s	sloon?						\/	AL.
an two pillows to s	nounde in	the pact year?					Yes	No
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use birth control r	medication	ıs?					Yes	No
stions to the be health care p	est of my provider	y knowledge. Sh	ould further in	formatic	on be needed, you hav	e my perr	nissio	n to
ure					Date			
r	An two pillows to a ned more than 10 e you had any dis pregnant or think use birth control above informa stions to the be health care pealth or medica	Yes No an two pillows to sleep?ned more than 10 pounds in e you had any disease, concerpregnant or think you may use birth control medication above information is not stions to the best of me health care provider ealth or medication.	Annee, etc.) Yes No Chemotherapy Yes No Tumors	rnee, etc.) Yes No Chemotherapy	rnee, etc.) Yes No Chemotherapy	rnee, etc.) Yes No Chemotherapy	rnee, etc.) Yes No Chemotherapy Yes No Nervous/Anxious	rice, etc.) Yes No Chemotherapy Yes No Nervous/Anxious Yes Yes No Tumors Yes No Psychiatric/Psychological Care Yes an two pillows to sleep? Yes ned more than 10 pounds in the past year? Yes e you had any disease, condition, or problem not listed? Yes pregnant or think you may be pregnant? Yes, Months No Nursing? Yes No use birth control medications? Yes above information is necessary to provide me with dental care in a safe and efficient manner. I have stions to the best of my knowledge. Should further information be needed, you have my permission to the health care provider or agency, who may release such information to you. I will notify the dentist ealth or medication.