Periodontal Associates, Inc.

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Cary N. Feuerman, D.M.D.

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ALL INFORMATION WILL BE HELD IN STRICT CONFIDENCE

Address:	Patient:				Home Te	I. No:		
Spouse's Name: Email:	Address:							
Spouse's Name: Email: Date of Birth: Date of Birth:								
Address: Date of Birth:	Snouse's Name:							
Dentist: Address:								
Address:	(if different from yours)				Date of f	oitui		
Address:	Dentist							
Physician:	Addragg							
Address: Have you been tested for HIV or Aids virus?	Address:							
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	LOW BLOOD PRESSURE							
LIVER TROUBLE	EXCESSIVE THIRST				·			
	LIVER TROUBLE				·			

DATE: _____ PATIENT SIGNATURE: ____