

PATIENT REGISTRATION

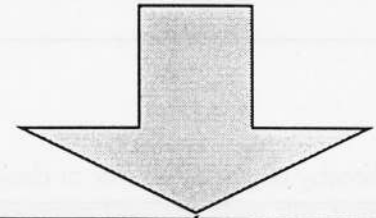
PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

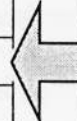
DATE				1
NAME				
SPOUSE				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.				
BIRTHDATE	AGE	MALE	FEMALE	
MARRIED	SINGLE	DIVORCED	WIDOWED	
SOCIAL SECURITY NO.				
DATE				
NAME				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.				
BIRTHDATE	AGE	MALE	FEMALE	
SCHOOL			GRADE	
SOCIAL SECURITY NO.				
IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS. FILL IN THE TOP BOX ALSO				

IF THIS APPOINTMENT IS FOR CHILD START HERE

DENTAL INSURANCE		2
PRIMARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYEE		
DATE OF BIRTH	DATE EMPLOYED	
UNION OR LOCAL NO.		
EMPLOYEE NO.		
EMPLOYEE SOCIAL SECURITY NO.		
SECONDARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYEE		
DATE OF BIRTH	DATE EMPLOYED	
UNION OR LOCAL NO.		
EMPLOYEE NO.		
EMPLOYEE SOCIAL SECURITY NO.		



ACCOUNT INFORMATION		4
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT		
ADDRESS		
CITY		STATE ZIP
PHONE NO.		
YOU		
NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS		CITY
BUSINESS PHONE NO.		EXT.
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS		CITY
BUSINESS PHONE NO.		EXT.



GETTING TO KNOW YOU		3
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
NAME:	RELATIONSHIP:	
REFERRED TO US BY		
YOUR FORMER ADDRESS		
CITY		STATE ZIP
PERSON TO CONTACT FOR EMERGENCY		
PHONE NUMBER		
ADDRESS		
CITY		STATE ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NUMBER		
ADDRESS		
CITY		STATE ZIP

Please turn over and sign

CONSENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.
4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% finance charge (18 % APR) may be added to my account.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

Patient Name _____

MEDICAL HISTORY

Patient Account No. _____

Medical Alert _____

1. Have you been under the care of a medical doctor during the past two years? Yes No

If yes, for what? _____

Physician's Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

2. Have you taken any medication or drugs during the past two years? Yes No

3. Are you taking any medication, drugs or pills now? Yes No

If yes, please list name and dosage _____

4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? Yes No

If yes, please list: _____

5. Have you been a patient in the hospital during the past five years? Yes No

6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

- | | | | | | |
|---|----|------------------------------|----|--|----|
| Heart (Surgery, Disease, Attack) Yes | No | Ulcers Yes | No | Hepatitis A (infectious) B (serum) Yes | No |
| Chest Pain Yes | No | Diabetes Yes | No | Venereal Disease Yes | No |
| Congenital Heart Disease Yes | No | Thyroid Problems Yes | No | A.I.D.S. Yes | No |
| Heart Murmur Yes | No | Glaucoma Yes | No | H.I.V. Positive Yes | No |
| High Blood Pressure Yes | No | Contact lenses Yes | No | Cold Sores/Fever Blisters Yes | No |
| Mitral Valve Prolapse Yes | No | Emphysema Yes | No | Blood Transfusion Yes | No |
| Artificial Heart Valve Yes | No | Chronic Cough Yes | No | Hemophilia Yes | No |
| Heart Pacemaker Yes | No | Tuberculosis Yes | No | Sickle Cell Disease Yes | No |
| Rheumatic Fever Yes | No | Asthma Yes | No | Bruise Easily Yes | No |
| Arthritis/Rheumatism Yes | No | Hay Fever Yes | No | Liver Disease Yes | No |
| Cortisone Medicine Yes | No | Latex Sensitivity Yes | No | Yellow Jaundice Yes | No |
| Swollen Ankles Yes | No | Allergies or Hives Yes | No | Neurological Disorders Yes | No |
| Stroke Yes | No | Sinus Trouble Yes | No | Epilepsy or Seizures Yes | No |
| Diet (Special: Restricted) Yes | No | Radiation Therapy Yes | No | Fainting or Dizzy Spells Yes | No |
| Artificial Joints (hip, knee, etc.) Yes | No | Chemotherapy Yes | No | Nervous/Anxious Yes | No |
| Kidney Trouble Yes | No | Tumors Yes | No | Psychiatric/Psychological Care Yes | No |

7. Do you use more than two pillows to sleep? Yes No

8. Have you lost or gained more than 10 pounds in the past year? Yes No

9. Do you have or have you had any disease, condition, or problem not listed? Yes No

If yes, please list: _____

10. Women. Are you: Pregnant? Yes, ___ Months No Nursing? Yes No Taking birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient /Guardian Signature _____ Date _____

History Review

Doctor Signature _____ Date _____

Patient Name _____

DENTAL HISTORY

Patient Account No. _____

Medical Alert _____

*Welcome! So that we may provide you with the best possible care
please complete both sides of this medical/dental history form.
All information is completely confidential.*

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold? Yes No

Sweets? Yes No

Biting or Chewing? Yes No

Have you noticed any mouth odors or bad tastes? Yes No

Do you frequently get cold sores, blisters or

any other oral lesions? Yes No

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease

or tooth loss? Yes No

Have you noticed any loose teeth or change

in your bite? Yes No

Does food tend to become caught in between

your teeth? Yes No

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep? Yes No

Bite your lips or cheeks regularly? Yes No

Hold foreign objects with your teeth?

(pencils, pipe, pins, nails, fingernails) Yes No

Mouth breath while awake or asleep? Yes No

Have tired jaws, especially in the morning? Yes No

Smoke/chew tobacco? Yes No

Have you ever had:

Orthodontic treatment? Yes No

Oral surgery? Yes No

Periodontal treatment? Yes No

Your teeth ground or the bite adjusted? Yes No

A bite plate or mouth guard? Yes No

A serious injury to the mouth or head? Yes No

If so, please describe, including cause _____

Have you experienced:

Clicking or popping of the jaw? Yes No

Pain? (joint, ear, side of face) Yes No

Difficulty in opening or closing the mouth? Yes No

Difficulty in chewing on either side of the mouth? Yes No

Headaches, neckaches or shoulder aches? Yes No

Sore muscles (neck, shoulders)? Yes No

Are you satisfied with your teeth's appearance? Yes No

Would you like to keep all of your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe _____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

(Please complete other side)