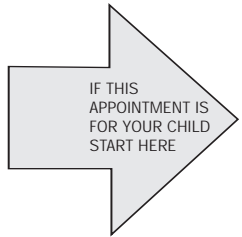


PATIENT REGISTRATION

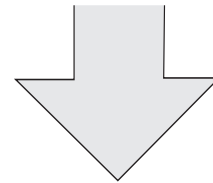
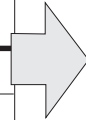
PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION



DATE				1
NAME				
SPOUSE				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.				
BIRTHDATE	/	/	AGE	MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>
MARRIED <input type="checkbox"/>	SINGLE <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	
SOCIAL SECURITY NO.				
DATE				
NAME				
SPOUSE				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.				
BIRTHDATE	/	/	AGE	MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>
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				



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
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

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 _____ 's (name of patient) 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 _____

DENTAL HISTORY

PATIENT NAME	
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 _____ City _____ 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: Yes No

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

Bit your lips or cheeks regularly? Yes No

Hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails)? Yes No

Mouth breathe 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 chewing on either side of the mouth? Yes No

Headaches, neckaches or shoulder aches? Yes No

Sore muscles (neck, shoulders)? Yes No

Are you satisfaction 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? Yes No

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: _____

MEDICAL HISTORY

PATIENT NAME	
PATIENT ACCOUNT NO.	MEDICAL ALERT

1. Have you been under the care of 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, B, or C | 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	
Dentist Signature	Date