PATIENT INFORMATION AND REGISTRATION

All responses in this form are strictly confidential and will become part of your medical record.

PATIENT INFORMATION			
NAME *(Last, First, MI)*:		☐M ☐F ☐U	**DOB:**
MARITAL STATUS: ☐Single ☐Partnered ☐Married ☐Divorced ☐Widowed		**SSN:**	
WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?		**REASON FOR VISIT:**	

RESPONSIBLE PARTY INFORMATION			
NAME *(Last, First, MI)*:		☐M ☐F ☐U	**DOB:**
MARITAL STATUS: ☐Single ☐Partnered ☐Married ☐Divorced ☐Widowed		**SSN:**	
RELATIONSHIP TO PATIENT:		**DRIVER'S LICENSE NUMBER:**	
CONTACT INFORMATION	**STREET:**	**CITY, STATE, ZIPCODE:**	
	HOW LONG AT THIS ADDRESS?		
	PREVIOUS ADDRESS *(if less than 3 years)*:		
	HOME PHONE:	**CELL PHONE:**	
	WORK PHONE:	**E-MAIL:**	
	EMPLOYER:	**NUMBER OF YEARS EMPLOYED:**	

RESPONSIBLE PARTY'S SPOUSE		EMERGENCY CONTACT (NOT LIVING WITH YOU)	
NAME:		**NAME:**	
DOB:	**SSN:**	**STREET:**	
EMPLOYER:	**OCCUPATION:**	**CITY, STATE:**	**RELATIONSHIP:**
HOME PH:	**CELL PH:**	**HOME PH:**	**CELL PH:**
WORK PH:	**E-MAIL:**	**WORK PH:**	**E-MAIL:**

PRIMARY DENTAL INSURANCE INFORMATION		If you have double dental insurance, complete this for the second coverage.	
INSURED'S NAME:		**INSURED'S NAME:**	
INSURANCE CO:		**INSURANCE CO:**	
INSURANCE CO. ADDRESS:		**INSURANCE CO. ADDRESS:**	
INSURED'S EMPLOYER:	**GROUP #:**	**INSURED'S EMPLOYER:**	**GROUP #:**
INSURED'S SSN:	**LOCAL #:**	**INSURED'S SSN:**	**LOCAL #:**

PERSONAL HEALTH HISTORY

It is important to be truthful and accurate about your Medical and Dental History. These facts have a direct bearing on your dental health. All responses in this form are strictly confidential and will become part of your medical record. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY		
HOW LONG since you have seen a dentist?	**YES**	**NO**
LAST COMPLETE Dental Exam, date:		
LAST FULL MOUTH X-rays, date:		
Are you having any dental PROBLEMS now? If so, please describe:	☐	☐

Is your present dental health POOR?	☐	☐
Do you wear DENTURES? If so, PARTIALS or FULL?	☐	☐
Are you UNHAPPY with your dentures?	☐	☐
Would you like to know about PERMANENT REPLACEMENTS?	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐
Have you ever had PERIODONTAL (GUM) TREATMENTS?	☐	☐
Do your gums BLEED, feel TENDER, or feel IRRITATED?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets, pressure? If so, please describe:	☐	☐
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES, or NECK PAINS?	☐	☐
Have you worn BRACES on your teeth (ORTHODONTICS)?	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐
NAME OF PREVIOUS DENTIST:		
CITY, STATE:		

Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment:

FEAR OF PAIN:	**LACK OF CONCERN:**
COST OF TREATMENT:	**MISSING WORK TIME:**

MEDICAL HISTORY		
	YES	**NO**
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you currently under a PHYSICIAN'S CARE? Please describe:	☐	☐
NAME OF PHYSICIAN:		
PHYSICIAN PHONE:		
PHYSICIAN E-MAIL:		
Have you ever taken FEN-PHEN/REDUX?	☐	☐
Have you ever used a BISPHOSPHONATE MEDICATION? *Brand names include Fosamax, Actonel, Boniva, and Didronel.*	☐	☐
Are you PREGNANT?	☐	☐
Do you use CIGARS, CIGARETTES, PIPE TOBACCO, or CHEWING TOBACCO? Please circle.	☐	☐

Please CHECK yes or no to the following which you HAVE HAD, or PRESENTLY HAVE:

	Y	N		Y	N		Y	N
AIDS/HIV	☐	☐	**Artificial Heart Valves**	☐	☐	**Back Problems**	☐	☐
Anaphylaxis	☐	☐	**Artificial Joints**	☐	☐	**Blood Disease**	☐	☐
Anemia	☐	☐	**Asthma**	☐	☐	**Cancer** *(specify:)*	☐	☐
Arthritis	☐	☐	**Atopic** *(allergy prone)*	☐	☐	**Chemical Dependency**	☐	☐

Chemotherapy	☐	☐	**Hemophilia**	☐	☐	**Respiratory Disease**	☐	☐
Circulatory Problems	☐	☐	**Herpes**	☐	☐	**Rheumatic/Scarlet Fever**	☐	☐
Cortisone Treatments	☐	☐	**Hepatitis** *(please specify A, B, or C)*	☐	☐	**Shingles**	☐	☐
Cough *(persistent)*	☐	☐	**High Blood Pressure**	☐	☐	**Shortness of Breath**	☐	☐
Coughing Up Blood	☐	☐	**Jaw Pain**	☐	☐	**Skin Rash**	☐	☐
Diabetes	☐	☐	**Kidney Disease/Malfunction**	☐	☐	**Spina Bifida**	☐	☐
Epilepsy	☐	☐	**Liver Disease**	☐	☐	**Stroke** *(date:)*	☐	☐
Fainting	☐	☐	**Material Allergy** *(latex, metal, etc.)*	☐	☐	**Surgical Implant**	☐	☐
Food Allergies	☐	☐	**Mitral Valve Prolapse**	☐	☐	**Swelling of Feet/Ankles**	☐	☐
Glaucoma	☐	☐	**Nervous Problems**	☐	☐	**Thyroid Disease**	☐	☐
Headaches	☐	☐	**Pacemaker/Heart Surgery**	☐	☐	**Tobacco Habit**	☐	☐
Heart Murmur	☐	☐	**Psychiatric Care**	☐	☐	**Tuberculosis**	☐	☐
Heart Problems *(please describe)*	☐	☐	**Rapid Weight Loss /Gain**	☐	☐	**Ulcer/Colitis**	☐	☐
			Radiation Treatment	☐	☐	**Venereal Disease**	☐	☐

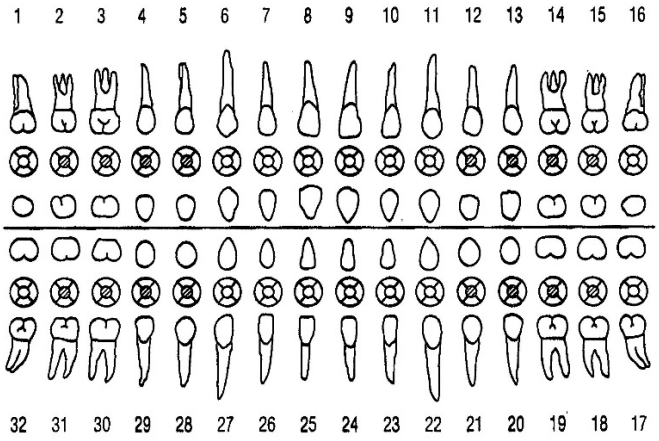
MEDICATIONS		
DRUG	**DOSAGE**	**FREQUENCY**

DRUG ALLERGIES/REACTIONS *(please check)*			
Aspirin	☐	**Nitrous Oxide**	☐
Local Anesthetic	☐	**Codeine**	☐
Penicillin	☐	**Erythromycin**	☐
Latex	☐		
Other medications *(please specify)*:			
Please describe any adverse reactions to the above medications:			

CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, prescribe and administer medications, and perform any therapy that may be indicated. I understand the use of anesthetic agents embodies a certain risk. I understand that dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance carrier will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand where appropriate, credit reports may be obtained.

PATIENT Signature (Parent of Child) _____ DATE: _____ DENTIST Signature _____



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