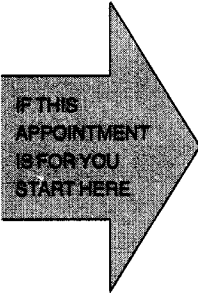


# PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

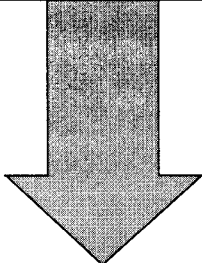


DATE				<b>1</b>
LAST NAME		FIRST	M.I.	
PREFERS TO BE CALLED BY				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.		FAX		
CELL		EMAIL		
BIRTHDATE	AGE	MALE	FEMALE	
MARRIED	SINGLE	DIVORCED	WIDOWED	
SOCIAL SECURITY NO.				
<hr/>				
DATE				
LAST NAME		FIRST	M.I.	
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.				
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

DENTAL INSURANCE		<b>2</b>
<b>PRIMARY CARRIER</b>		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		
<b>SECONDARY CARRIER</b>		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		



<b>ACCOUNT INFORMATION</b>		<b>4</b>
<b>PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT</b>		
NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
<b>YOU</b>		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	
<b>YOUR SPOUSE</b>		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	



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

*Please turn over and sign*

Patient Name \_\_\_\_\_  
 Patient Account No. \_\_\_\_\_

# DENTAL HISTORY

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? \_\_\_\_\_

Have you ever used or are currently using topical fluoride? Yes No

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 breathe while awake or asleep? Yes No  
 Have tired jaws, especially in the morning? Yes No  
 Snore or have any other sleeping disorders? Yes No  
 Smoke/chew tobacco or use other tobacco products? 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 \_\_\_\_\_

Have you ever been told to take a pre-medication prior to dental treatment? Yes No

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)

Patient Name \_\_\_\_\_  
 Patient Account No. \_\_\_\_\_

**MEDICAL HISTORY**

Medical Alert \_\_\_\_\_

1. Physician's Name \_\_\_\_\_ Phone (      ) \_\_\_\_\_  
 Have you had any medical care within the past two years? ..... Yes No  
 Describe \_\_\_\_\_
  2. Have you taken any medication or drugs during the past two years? ..... Yes No
  3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? ..... Yes No  
 If yes, please list name and dosage \_\_\_\_\_
  4. Have you ever taken prescription medications for weight loss (diet pills)? ..... Yes No  
 If yes, did you take any of the following? (circle if yes)      Fen-Phen      Pondimin      Redux      Other  
 If yes to any of the above, did you have a medical exam for heart issues? ..... Yes No
  5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? ..... Yes No
  6. Are you aware of having an allergic (or adverse) reaction to any substance or medication? ..... Yes No  
 If yes, please specify \_\_\_\_\_
  7. Have you been a patient in the hospital during the past five years? ..... Yes No
  8. 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 C (circle) ...     | 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./H.I.V. Positive .....   | Yes | No |
| Heart Murmur .....                       | Yes | No | Glaucoma .....                | Yes | No | Cold Sores/Fever Blisters .....  | Yes | No |
| High/Low Blood Pressure .....            | Yes | No | Contact lenses .....          | Yes | No | Blood Transfusion .....          | Yes | No |
| Mitral Valve Prolapse .....              | Yes | No | Emphysema .....               | Yes | No | Hemophilia .....                 | Yes | No |
| Artificial Heart Valve/Pacemaker .....   | Yes | No | Chronic Cough .....           | Yes | No | Sickle Cell Disease .....        | Yes | No |
| Rheumatic Fever .....                    | Yes | No | Tuberculosis .....            | Yes | No | Bruise Easily .....              | Yes | No |
| Arthritis/Rheumatism .....               | Yes | No | Asthma .....                  | Yes | No | Liver Disease/Yellow Jaundice .. | Yes | No |
| Cortisone Medicine .....                 | Yes | No | Hay Fever/Allergy/Hives ..... | Yes | No | Neurological Disorders .....     | Yes | No |
| Swollen Ankles .....                     | Yes | No | Latex Sensitivity .....       | Yes | No | Epilepsy or Seizures .....       | Yes | No |
| Stroke .....                             | Yes | No | Sinus Trouble .....           | Yes | No | Fainting or Dizzy Spells .....   | Yes | No |
| Diet (Special/Restricted) .....          | Yes | No | Radiation Therapy .....       | Yes | No | Nervous/Anxious .....            | Yes | No |
| Artificial Joints (hip, knee, etc.) .... | Yes | No | Chemotherapy .....            | Yes | No | Psychiatric/Psychological Care.. | Yes | No |
| Kidney Trouble .....                     | Yes | No | Tumors .....                  | Yes | No |                                  |     |    |
9. Have you lost or gained more than 10 pounds in the past year? ..... Yes No
  10. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No  
 If yes, please list: \_\_\_\_\_
  11. **Women:** Are you pregnant or think you could be pregnant? Yes \_\_\_\_\_ Months No      **Nursing?** Yes No
  12. Do you use birth control prescriptions? ..... 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 \_\_\_\_\_

## CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and 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 agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. 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% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Parent/Responsible Party's Signature \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

## PERSONALIZED ESTHETIC EVALUATION

- |  |     |    |
|--|-----|----|
| 1. Do you dislike the color of your teeth?                               | Yes | No |
| 2. Do you have spaces between your teeth?                                | Yes | No |
| 3. Do you have chips or uneven edges on your teeth?                      | Yes | No |
| 4. Do you have any dark fillings visible?                                | Yes | No |
| 5. Are your teeth too short?   | Yes | No |
| 6. Are your teeth too long?  | Yes | No |
| 7. Are your teeth too crowded?   | Yes | No |
| 8. Do your teeth feel "notched" at the gum line?                         | Yes | No |
| 9. Do your gums show when you are smiling?                               | Yes | No |
| 10. Do your gums feel unhealthy?   | Yes | No |
| 11. Do your gums feel irregular in contour?                              | Yes | No |
| 12. Have you ever had orthodontic treatment?                             | Yes | No |
| 13. Are you satisfied with your facial appearance?<br>If not, why? _____ | Yes | No |
| 14. If your smile were improved, would you feel more satisfied?          | Yes | No |
| 15. In general, how would you improve your smile? _____                  |     |    |