Clarence C. Kegler II, DDS, PC

PATIENT REGISTRATION

Patient Name:_____ Birth Date:_____

Name you go by:_____ SSN:_____

Street Address:_____ Age:____ Sex: M F

City:_____ State:_____ Zip:_____

E-Mail:_____ Home Phone#:_____

Pager:_____ Cellular Phone#:_____

Marital Status:_____

(If a minor, person responsible for client):_____

Patient Occupation or School:_____ Work Phone #: _____

Business Name & Address:_____

City:_____ State:_____ Zip:_____

Spouse's Name & Occupation:_____

Business Name & Address:_____

Business Phone & Extension:_____

City:_____ State:_____ Zip:_____

Who can we thank for referring you? _____

Is another member of your family a patient? Name:_____

Person to contact in case of an emergency:_____ Phone #:_____

Closest relative not living with you:_____ Phone #:_____

Street:_____ City:_____ State:_____ Zip:_____

Name of insured:_____ SSN:_____

Dental Insurance Company: _____ Policy #: _____

Dental Insurance Group #:_____ Date of Birth:_____

Secondary Insurance Company:_____ Policy #:_____

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Name:_____ Date:_____/_____/_____

DIRECTIONS: The following information about your health history is very important to us to provide you with the best possible dental care in a safe way. Incorrect information may be dangerous to your health. ALL questions must be answered completely and accurately. If you don't understand a question, or are unsure of the answer, or want to discuss it with the dentist, circle its number, letter or word. The Health History Questionnaire will become a part of your dental treatment record and will be considered confidential information. (If you are completing this form for a dependent, answer as per their history.)

MEDICAL HISTORY

1. Have you been a patient in the hospital during the past two years?.....YES NO
2. Have you been under the care of a medical doctor during the past two years?.....YES NO
   Physician's Name_____
   Address:_____Phone #:_____
3. Have you taken any medication during the past two years?..... YES NO
   Are you now taking any medication, drugs or pills?.....YES NO
   If yes, please list those drugs and conditions they treat:_____
   _____
4. Are you aware of being allergic to any medication or substance?.....YES NO
   If yes, please list:_____

5. Do you or have you ever had any of the following?

° Heart Disease	° Stroke	° Neurological Disorder
° Angina Pectoris	° Epilepsy or Seizures	° Arthritis/Rheumatism
° High Blood Pressure	° Fainting or Dizzy Spells	° Glaucoma
° Heart Murmur	° Radiation Treatment	° Fever Blisters/Cold Sores
° Rheumatic Fever	° Chemotherapy	° Venereal Disease
° Congenital Heart Conditions	° Cancer	° Special Diet
° Heart Surgery or Pacemaker	° Kidney Trouble	° Hepatitis
° Artificial Heart Valve or Joints	° Ulcer/Stomach Disorders	° Liver Disease
° Anemia	° Emphysema	° Jaundice
° Sickle Cell Disease	° Tuberculosis (TB)	° Drug or Alcohol Addiction
° H.I.V. Positive (AIDS)	° Asthma or Bronchitis	° Skin Conditions
° Leukemia	° Hay Fever or Sinusitis	° Latex Allergy
° Hemophilia (free bleeding)	° Thyroid Disease	° Mitral Valve Prolapse
° Bruise Easily	° Diabetes/Blood Sugar Problems	° Other

6. Do your ankles swell?.....YES NO
7. Severe or frequent headaches? Sinus problems?.....YES NO
8. Phobias, severe anxieties, depression, psychoses, unusual fears, or other related conditions? YES NO
9. Do you have complaints/conditions regarding your eyes, ears, or nose?.....YES NO
10. How many packs of cigarettes do you smoke per day?....._____packs per day
11. How many drinks of beer, wine or liquor do you drink?....._____per week

FOR WOMEN ONLY:

Are you pregnant? ° YES ° NO If yes, what month?_____Are you taking birth control pills? ° YES ° NO

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DENTAL HISTORY

Name: _____

1. What is your major dental concern? _____
2. Date of your last visit to a dentist? _____
3. Date you last had a dental x-ray taken? _____
4. What wold you do to change your smile? _____
5. Do you brush and floss daily? ..... YES NO
6. Have you always had your teeth cleaned at least once a year? ..... YES NO
7. Do your gums bleed when you brush your teeth or when you eat? ..... YES NO
8. Does food or dental floss catch between your teeth? ..... YES NO
9. Are any of your teeth sensitive to hot, cold or pressure? ..... YES NO
10. Do you experience pain or clicking in your jaw joints? ..... YES NO
11. Have you had any injury to your teeth, jaws or face? ..... YES NO
    If yes, explain: _____
12. Are you worried or nervous about receiving dental treatment? ..... YES NO
13. Have you ever fainted during a dental visit? ..... YES NO
    If yes, explain: _____
14. Have you experienced an unusual reaction into dental medication or anesthetic? ..... YES NO
15. Have you experienced prolonged bleeding following dental treatment? ..... YES NO
16. Have you had any other complications following dental treatment? ..... YES NO
    If yes, explain: _____
17. Do you have any other dental concerns or complaints? ..... YES NO
    If yes, explain: _____

Patient Signature: _____ Date: _____

Updated Health History Patient Signature: _____ Date: _____

(Doctor's Use) HISTORY REVIEW

_____

_____

_____

_____

_____

_____

Reviewed by: _____ Date: _____

Shared Responsibilities for Dental Success

1. Treatment Responsibility

We are responsible for informing you of your current oral health conditions. We will provide you with the best care and treatment to reach your desired health. We are responsible for telling you the consequences of not receiving the recommended treatment. Once you decide and begin your treatment plan, it is important to complete it. Incomplete treatment leads to the loss of teeth and further disease. You are responsible for continuing your care both in our office, and maintaining your proper home care. You are responsible for staying on track with your desired treatment plan to its completion. Some treatment plans, because of their design, take years to complete.

2. Appointment Responsibility

We are responsible for reserving time for each patient and rarely do we ever keep our patients waiting. An appointment written in our schedule with your name is a bond of trust that we will be here to serve you. You are responsible to be present when you reserve that time with us. We must have mutual respect for each other's time. Therefore, we require 48 hours advance notice if your appointment needs to be rescheduled.

3. Financial Agreement Responsibility

We believe that we have a responsibility to use our best professional care, skill and judgment in planning for your dental treatment. We are responsible for explaining and discussing fees to you in advance. We will accept payment for services as they are rendered, unless a payment arrangement is made in advance. You are responsible for paying your portion at the agreed time. Should insurance not pay for their portion, for whatever reason, you are ultimately responsible for all fees. No business or practice can fulfill its mission to its patients when a bond of trust is violated by failure to pay for services.

CONSENT TO TREATMENT

I acknowledge that the nature and extent of my dental treatment needs have been fully presented to me. I acknowledge that the nature and purpose of the treatment given, the reasonable alternative including not treatment, and the important risk of this treatment and consequences of not getting treatment have been fully explained to me in terms and language I understand. I understand the fees quoted are only an estimate of the actual charge that may be incurred in treatment. I understand any additional work required but not listed will be at additional expense to me. I understand fees are not returnable and all fees are due and payable prior to completion of the above treatment. Estimated fees will be guaranteed for 1 year from date of diagnosis. Our office will stand behind all treatment completed for 5 years as long as you stay current with your recommended check-ups.

CONSENT FOR PHOTOGRAPHS OR OTHER VISUAL DOCUMENTATION

I authorize the dentist and/or staff of Artistic Smiles, to make photographs or other images of my mouth or teeth. I understand that I will not be identified by name and that such materials will only be used in the most dignified circumstances. **I have read and fully understand the above.**

_____ _____ _____

Signature of patient/guarantor Date Witness

SMILE EVALUATION

We would like to help you obtain the smile you've always wanted. Please take a few minutes to complete this short questionnaire. While using a mirror or looking at a photograph, please observe your teeth carefully.

1) Do you have any concerns about bad breath odor?

_____

2) Are you pleased with the appearance of your teeth when you smile?

_____

3) Are you pleased with the color of your teeth?

_____

4) Are you pleased with the shape of your teeth?

_____

5) Are there spaces between your teeth that you don't like?

_____

6) Are your teeth…

chipped? _____ protruding? _____ hidden? _____ crowded? _____

7) Do you like the way your teeth fit together when you bite?

_____

8) Are there old fillings or dental treatment that you aren't happy with?

_____

9) If you could change anything about the appearance of your smile, what would it be?

_____

10) Is there anything about the alignment of your jaws that you are not happy with?

_____