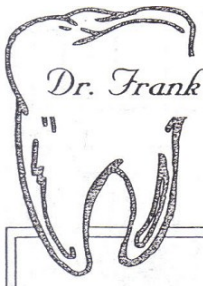

Dr. Frank Roach, D.D.S.

Today's Date _____

PATIENT'S INFORMATION

(please print)

First Name & Middle Initial _____
Last Name _____
Street Address _____
City _____ State _____
Zip Code _____
Email Address _____
Home Phone # _____
Work Phone # _____
Work Extension _____
Soc Sec # _____
Cell Phone or Pager # _____
Date of Birth (MM/DD/YYYY) _____ Age _____
Marital Status: Single Married
Male Female
Employer _____
Occupation _____
Employer Address _____

Is the patient the SAME person as the policy holder? (circle Yes or No)
If "Yes", then skip the rest of this box.
If "No", what is the relationship of the patient to the policyholder?
(circle one) Husband Wife Son Daughter Other _____

POLICY HOLDER'S INFORMATION

(please print)

First Name & Middle Initial _____
Last Name _____
Street Address _____
City _____ State _____
Zip Code _____
Email Address _____
Home Phone # _____
Work Phone # _____
Work Extension _____
Soc Sec # _____
Cell Phone or Pager # _____
Date of Birth (MM/DD/YYYY) _____ Age _____
Marital Status: Single Married
Male Female
Employer _____
Occupation _____
Employer Address _____

INSURANCE INFORMATION:

Policy Holder's Name _____
Primary Insurance Company _____ Policy # _____
Policy Holder's Name _____
Secondary Insurance Company _____ Policy # _____

IN CASE OF EMERGENCY, LIST YOUR NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU:

Name _____ Relationship _____
Address _____ Telephone # ( ) _____

HOW WERE YOU REFERRED TO US?:

_____ Friend or Family Member (Name) _____
Yellow Pages _____ www.dentistfirst.com _____ TV or Radio _____ NewspaperFlyer or Coupon _____ Other _____

Signature of person responsible for the payment of the account _____

PLEASE TURN THIS SHEET OVER AND FILL OUT THE MEDICAL HISTORY FORM

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. When did you last receive dental treatment? _____
   What type of treatment? _____
2. Previous Dentist _____
   City, State _____
3. Do you have dentures, partial dentures, bridges or crowns?
   If yes, when were they made? _____ Y N
4. Date of last physical examination _____
5. Have you been hospitalized during the past three years?
   Y N
6. Have you had any serious illness in the past three years?
   If so, please explain _____ Y N
7. Are you under a physician's care? Y N
   If yes, for what condition? _____
8. Have you ever worn braces? Y N
9. Have you ever had gum surgery? Y N
10. Have you ever had any difficulty with any dental work or extractions? Y N
11. Have you had any surgical prostheses? Y* N
    (Joint replacements or implants)

Do you have or have you had any of the following conditions or diseases?

CARDIOVASCULAR

20. Rheumatic Fever	Y*	N
21. Congenital Heart Defect	Y*	N
22. Angina or Heart Attack	Y*	N
23. Heart Murmurs	Y*	N
24. Congestive Heart Failure	Y	N
25. Heart Surgery or Pacemaker	Y*	N
26. (High) or (Low) Blood Pressure (Circle One)	Y	N
27. Stroke	Y	N

RESPIRATORY DISEASE

30. Asthma or Bronchitis	Y	N
31. Emphysema	Y	N
32. Hay Fever or Sinusitis	Y	N

ENDOCRINE DISORDERS

40. Diabetes	Y	N
41. (Hyperthyroidism) or (Hypothyroidism) (cicle one)	Y	N

BLOOD DISORDERS

50. Anemia	Y	N
51. Do you bleed excessively when cut?	Y	N

KIDNEY DISEASE

60. Have you ever had any kidney infections?	Y	N
61. Have you had kidney surgery?	Y	N

INFECTIOUS DISEASE

70. Hepatitis	Y	N
71. Venereal Disease (Within the last 10 years)	Y	N
72. Tuberculosis	Y	N
73. HIV Positive	Y	N

* If you answered "Y" to any of the starred questions, current American Heart Association standards require that you take antibiotics immediately before each dental appointment. If you fail to do so we will be required to reschedule your appointment unless we receive a written exemption from a physician.

_____

DOCTOR'S SIGNATURE DATE

MISCELLANEOUS DISEASE AND DISORDERS

80. Frequent Fainting	Y	N
81. Liver Disease	Y	N
82. Arthritis	Y	N
83. Ulcers	Y	N
84. Glaucoma	Y	N
85. Radiation Therapy for Cancer	Y	N
86. Epilepsy	Y	N
87. Cancer	Y	N
88. Do you smoke?	Y	N
89. Do you use any other form of tobacco?	Y	N

Are you currently taking any of the following drugs or medications?

90. Antibiotics	Y	N
91. Blood Thinners	Y	N
92. Steroids or Cortisone	Y	N
93. High Blood Pressure Medicine	Y	N
94. Tranquilizers	Y	N
95. Aspirin	Y	N

Please write down all of the prescribed medications you are currently taking: _____

_____

_____

Do you have an ALLERGY or reaction to any of the following medications?

100. Local Anesthetics	Y	N
101. Penicillin	Y	N
102. Other Antibiotics	Y	N
103. Codeine	Y	N
104. Other Pain Medication	Y	N
105. Other Medicines	Y	N

If yes, what medicines? _____

Do you have any medical problems not listed above? If yes, please explain: Y N _____

WOMEN ONLY

110. Are you pregnant? Y N
If yes, when are you due?

_____

PATIENT'S SIGNATURE DATE
(Parents must sign for their minor children)

PATIENT'S INITIALS FOR UPDATE: **DATE:**
(Parents must sign for their minor children)

_____ _____

_____ _____

_____ _____

_____ _____