IN EVENT OF EMERGENCY

Who should we contact? _____

Relation: _____

Home Phone: _____

Work Phone: _____

ENTERED IN SYSTEM

REGISTRATION INFORMATION

RESPONSIBLE PARTY

Name of person responsible for account:

_____ (Last Name) _____ (First Name) _____ (Middle Initial)

Street Address _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____

Email Address _____ Website Address _____

Birthdate _____ Soc. Sec. # _____ Marital Status: _____ Sex _____ (M or F)

Referral Source _____ Adult Driver License # _____ State _____

Employer name _____

Address: _____

DENTAL INSURANCE

Insurance Co. _____

Address _____

Name of Group Dental Program _____

Group No. _____ Union Local _____ Subs. No. _____

MEDICAL/SURGICAL INSURANCE

Insurance Co. _____

Address _____

Group Number _____ Subscriber No. _____

SPOUSE

Name of spouse of person named above:

_____ (Last Name,) _____ (First Name) _____ (Middle Initial)

Marital Status: _____ Sex code _____ (M or F)

Birthdate: _____ Soc. Sec. No. _____

Employer Name: _____

Address: _____

Dental Insurance Company: _____

Address: _____

Group number: _____ Union Local: _____

Medical Insurance Company: _____

Address: _____

DEPENDENTS

Name	Date of Birth	Sex	Covered by Dental Insurance Through:

CONSENT:

The undersigned hereby authorizes 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 Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance charge will be added to any overdue balance. I also assign all insurance benefits to the Doctor.

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

Credit Check _____ **By** _____

Patient Name	DENTAL HISTORY
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 _____ State _____ Zip _____

Address _____

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?

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
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 opening or closing the mouth? Yes No
Difficulty in chewing on either side of the mouth? Yes No
Headaches, neck aches of 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_____

_____

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)

MEDICAL HISTORY

Patient Name	
Patient Account No.	Medical Alert

1. Have you been under the care of a 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 of drugs the past two years? Yes No
3. Are you taking any medication, drug or pills now? 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:
   Yes No Fen-Phen (Fenfluramine-Phenopermine)
   Yes No Pondimen (Fenfluramine)
   Yes No Redux (Dexfenfluramine)
   If yes to any of the above, did you have a medical exam for heart issues? Yes No
5. Are you aware of having an allergic **(or adverse reaction)** to any medication or substance? Yes No
   If yes, please list: _____
6. Have you been a patient in the hospital during the past five years? Yes No
7. 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 (infectious) B (serum)	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

8. Do you use more than two pillows to sleep? 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?** 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 change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

DATE	B/P	DATE	B/P

Dentist Signature_____ **Date**_____

INFORMATION AND CONSENT AGREEMENT

Doctor_____

Patient_____ SS#_____
Please Print Parent or Guardian if Patient is a minor

Consent to Treatment: I hereby authorize and request the above named doctor(s) to provide me with dental treatment. This authorization shall also include any and all surgical procedures, which include the removal of hard and soft tissue or the correction thereof, after the procedure has been fully described, and to do whatever procedures that his/her judgment may dictate during the treatment with my consent. I authorize and request the administration of such anesthetic or anesthetics as may be deemed advisable by the doctor. It has been explained to me, and I understand, that a perfect result is not guaranteed or warranted, and that any limitations will be described to me at the time of the procedure.

Release of Information: You are authorized to release any information you deem appropriate concerning my dental condition to my insurance company, attorney, adjuster, or any other person necessary for you to process any claim for reimbursement of charges incurred by me at your office. (Please refer to our Notice of Privacy Practice).

Right to Receive Payment: I authorize and assign to you, the dental provider, the right to receive direct payment from my attorney, insurance company, or any other party who may be obligated to pay me any sums. I further authorize the endorsement of my name to any draft containing my name to which you are legally entitled.

Account Obligation: I understand that I remain responsible for any uncollected or unpaid balance on my account. I also understand that I am responsible for any deductibles and co-payments established by my insurance company. I understand that insurance is not a guaranteed of payment. The insurance company is responsible to the patient and the patient is responsible to Apex Dental Centers. W e cannot render services on the assumption that the charges will be paid by an insurance company. I agree to send any insurance payment I receive for dental services performed in this office to Apex Dental Centers, unless services are paid in full at the time of treatment.

I understand that I will be charged 30% and a $50.00 processing fee for any account turned over to collection and 50% of my balance and a $100.00 processing fee if my account is turned over to an attorney for legal purposes. I understand that a monthly late fee of $25.00 and/or finance charge of 1.5% will be applied to my account for any unpaid balance over 60 days, regardless of any pending insurance, workers' compensation or legal claims.

_____ _____
Patient Signature (parent or guardian if minor) Date