REGISTRATION

PATIENT'S
NAME_____
Last First Initial

IF CHILD:
PARENT'S NAME_____
Last First Initial

HOW DO YOU WISH
TO BE ADDRESSED_____

Single____ Married____ Separated____ Divorced____ Widowed____

DATE OF BIRTH _____

RESIDENCE - STREET_____

CITY_____STATE_____ZIP_____

TELEPHONE: RESIDENCE _____

PATIENT/PARENT EMPLOYED BY_____

BUSINESS ADDRESS_____

CITY_____STATE_____ZIP_____

TELEPHONE: BUSINESS _____

PRESENT POSITION_____

SPOUSE/PARENT NAME_____

SPOUSE EMPLOYED BY_____

SPOUSE BUSINESS TELEPHONE _____

PRESENT POSITION_____

WHO IS RESPONSIBLE FOR THIS ACCOUNT_____

METHOD OF PAYMENT_____

WHOM MAY WE THANK FOR THIS REFERRAL_____

_____

PATIENT/PARENT SOCIAL SECURITY NO._____

SPOUSE/PARENT SOCIAL SECURITY NO._____

SOMEONE TO NOTIFY IN CASE OF EMERGENCY NOT LIVING WITH

YOU_____

PHONE_____RELATIONSHIP_____

DENTAL INSURANCE 1ST COVERAGE

EMPLOYEE NAME_____

BIRTHDATE_____ RELATION TO PATIENT_____

EMPLOYER_____

ADDRESS_____

_____

NAME OF INSURANCE CO._____

ADDRESS_____

_____

TELEPHONE:_____

CONTRACT/POLICY #_____

UNION LOCAL OR GROUP #_____

SOCIAL SECURITY NO._____

DENTAL INSURANCE 2ND COVERAGE(IF ANY)

EMPLOYEE NAME_____

BIRTHDATE_____ RELATION TO PATIENT_____

EMPLOYER_____

ADDRESS_____

_____

NAME OF INSURANCE CO._____

ADDRESS_____

_____

TELEPHONE:_____

CONTRACT/POLICY#_____

UNION LOCAL OR GROUP#_____

SOCIAL SECURITY NO._____

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advise and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advise and treatment to another dentist.

I understand that I am responsible for all costs of dental treatment. If my account becomes delinquent (I have a balance still due 90 days from date of service), I agree that I will be liable for all costs, interest and actual attorney's fees incurred (up to and including 50% of the balance due) in the collection of the balance due. Interest will be added at 1% per month on any account due over thirty (30) days. I agree to a broken appointment charge of at least $25 for any appointment not cancelled at least 24 hours in advance. I understand that the broken appointment charge may be more based on the time and expertise necessary for the services to be rendered.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I attest to the accuracy of the information on this page.

PATIENT OR GUARDIAN'S SIGNATURE_____ DATE_____

MEDICAL HISTORY

PATIENT'S NAME_____
Last First Initial Date of Birth

CIRCLE THE APPROPRIATE ANSWER

1. Physician's Name_____Phone_____

   Address _____
2. Have you ever had a serious illness or operation? ..... YES NO

   If so, explain _____
3. Are you under a physician's care? ..... YES NO

   For what reason?_____
4. When was your last complete physical exam? _____
5. Are you taking any medication? ..... YES NO

   If yes, what? _____
6. Do you have any allergies? ..... YES NO
   Are you allergic to any medications or substances (i.e. latex or jewelry)? ..... YES NO

   If yes, what? _____
   Do you have any problems with penicillin, antibiotics, anesthetics or other medications? ... YES NO
7. Have you been treated for or been told you might have heart disease? ..... YES NO
   Do you have a pacemaker or an artificial heart valve implant? ..... YES NO
8. Are you aware of any heart murmurs? ..... YES NO
9. Have you ever been told that you need antibiotic premedication prior to dental visits? ... YES NO
10. Have you ever had rheumatic fever? ..... YES NO
11. Have you ever had surgery, radiation treatment, chemo treatment for a tumor, growth or other condition? ..... YES NO
12. Do you have high or low blood pressure? ..... YES NO
13. Do you have inflammatory diseases, such as arthritis or rheumatism? ..... YES NO
14. Do you have any artificial joints/prosthesis (i.e. artificial knee, hip)? ..... YES NO
15. Do you have any blood disorders, such as anemia, leukemia, etc.? ..... YES NO
16. Have you ever bled excessively after being cut or injured? ..... YES NO
17. Do you have any stomach problems? ..... YES NO
18. Do you have any kidney problems? ..... YES NO
19. Do you have any liver problems? ..... YES NO
20. Are you diabetic? ..... YES NO
21. Do you have asthma? ..... YES NO
22. Do you have epilepsy or seizure disorders? ..... YES NO
23. Have you ever been anorexic or bulemic? ..... YES NO
24. Do you have AIDS or HIV? ..... YES NO
25. Have you ever had hepatitis? ..... YES NO
26. Do you or have you had TB? ..... YES NO
27. Do you smoke? ..... YES NO
28. Do you consume alcoholic beverages on a daily basis?..... YES NO
29. Are you pregnant or suspect you may be? ..... YES NO
30. Do you have any disease, condition, or problem not listed? If so, please explain

    _____
31. Is there anything else we should know about your health that we have not covered in this

    form? _____
32. Would you like to speak to the Doctor privately about any problem? ..... YES NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S SIGNATURE _____ DATE_____

DENTIST'S/HYGIENIST'S SIGNATURE _____ DATE _____

DENTAL HISTORY

PATIENT'S NAME_____
Last First Initial

CIRCLE THE APPROPRIATE ANSWER

1. Purpose of initial visit _____

_____

2. Are you aware of a problem? _____

3. How long since your last dental visit? _____

4. What was done at that time? _____

5. Previous dentist's name _____
6. Have you made regular visits ..... YES NO

How often? _____
7. Were dental x-rays taken? ..... YES NO
8. Have you lost any teeth? ..... YES NO
9. Have they been replaced? ..... YES NO
10. Were they replaced with a fixed bridge, partial denture, or full denture? ..... YES NO

Type of replacement _____ Age_____
11. Are you happy with the replacement? ..... YES NO

If no, explain _____
12. Would you like to know about permanent replacements? ..... YES NO
13. Have you had any problems or complications with previous dental treatment? ..... YES NO

If yes, explain _____
14. Do you clench or grind your teeth? ..... YES NO
15. Does you jaw click or pop? ..... YES NO
16. Have you experienced any pain or soreness in the muscles of your face? ..... YES NO
17. Do you have frequent headaches, neck aches or earaches? ..... YES NO
18. Does food get caught between your teeth? ..... YES NO
19. Are any of your teeth sensitive to heat, cold, sweets, or pressure? ..... YES NO
20. Do your gums bleed or hurt? ..... YES NO

When? _____

21. How often do you brush your teeth? _____ When? _____
22. Do you use dental floss? ..... YES NO

How often? _____
23. Are any of your teeth loose, tipped or shifted? ..... YES NO
24. Have you ever worn braces on your teeth? ..... YES NO
25. Do you have any discolored teeth that bother you? ..... YES NO
26. Do you feel that your breath is offensive at times? ..... YES NO
27. Have you ever had gum treatment or surgery? ..... YES NO

When? _____
28. Have you had any wisdom teeth removed? ..... YES NO
29. Are you happy with the appearance of your teeth? ..... YES NO
30. Have you had any unpleasant dental experiences? ..... YES NO
31. Do you have any questions or concerns? ..... YES NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S SIGNATURE _____ DATE_____