TODAY'S DATE_____

PATIENT'S
NAME _____
LAST FIRST INITIAL

IF CHILD,
PARENT'S NAME _____
LAST FIRST INITIAL

HOW DO YOU WISH
TO BE ADDRESSED _____

CHILD SINGLE MARRIED SEPARATED DIVORCED WIDOWED

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE HOME _____ WORK _____

CELL _____ OTHER _____

EMAIL ADDRESS _____

PATIENT/PARENT EMPLOYED BY _____

PRESENT POSITION _____ HOW LONG _____

SPOUSE/PARENT NAME _____

SPOUSE EMPLOYED BY _____

PRESENT POSITION _____ HOW LONG _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT _____

DRIVERS LICENSE NO _____

METHOD OF PAYMENT INSURANCE CREDIT CARD CASH

PURPOSE OF VISIT _____

OTHER FAMILY MEMBERS IN OUR PRACTICE _____

_____

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)

_____
NAME PHONE

RELATIONSHIP _____

PATIENT'S
DATE OF BIRTH _____ MALE FEMALE

DENTAL INSURANCE

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

EMPLOYER _____

NAME OF INSURANCE CO _____

TELEPHONE _____

POLICY # _____

GROUP # _____

SUBSCRIBER ID _____

SOCIAL SECURITY NO _____

I understand that my dental insurance is an agreement between myself, my employer, and the insurance carrier, or payor of benefits. I understand that my insurance carrier, or payor of my dental benefits, may pay less than the actual bill of services. I understand that I am financially responsible for payments in full of all accounts including amounts not covered by my insurance. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole, or in part by my insurance carrier or payor of benefits.

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

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

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 SIGNATURE

_____
DATE

REGISTRATION

PATIENT'S NAME _____
LAST FIRST INITIAL DATE OF BIRTH

Purpose of initial visit _____

Are you aware of a problem? _____

How long since your last dental visit? _____

What was done at that time? _____

Previous Dentist's Name _____

City _____ State _____ Telephone _____

When was the last time your teeth were cleaned? _____

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

1. Have you made regular visits? ..... YES NO
2. How often? .....
3. Were dental x-rays taken? ..... YES NO
4. Have you lost any teeth or have any teeth been removed? ..... YES NO
   Why? .....
5. Have they been replaced? ..... YES NO
6. How have they been replaced?
   - Fixed bridge Date .....
   - Removable bridge Date .....
   - Partial or Denture Date .....
   - Implant Date .....
7. Are you unhappy with the replacement? ..... YES NO
   If yes, please explain .....
   .....
8. Do you clench or grind your teeth? ..... YES NO
9. Does your jaw click or pop? ..... YES NO
10. Have you experienced any pain or soreness in the muscles of your face or around your ear? ..... YES NO
11. Do you have frequent headaches, neck aches, or shoulder aches? ..... YES NO
12. Does food get caught in your teeth? ..... YES NO
13. Are any of your teeth sensitive to hot? cold? sweets?
14. Do your gums bleed or hurt? ..... YES NO
    When? .....
15. How often do you brush your teeth? ..... When? .....
16. Do you use dental floss? ..... How often? .....
17. Are any of your teeth loose, tipped, shifted or chipped? ..... YES NO
18. Are you unhappy with the appearance of your teeth? ..... YES NO
19. How do you feel about your teeth in general? .....
    .....
20. Do you feel your breath is offensive at times? ..... YES NO
21. Have you ever had gum treatment or surgery? ..... YES NO
    What type? ..... Date? .....
    Where? .....
22. Have you had orthodontic treatment? ..... YES NO
23. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? ..... YES NO
24. Do you have any questions or concerns? ..... YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

COMMENTS

ANEST.

DENTALHISTORY

Med. Alert

PATIENT'S NAME _____
LAST FIRST INITIAL DATE OF BIRTH

Physician's Name _____

City _____ State _____ Telephone _____

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

1. Are you under a physician's care? YES NO
2. Since When: _____ Reason: _____
3. When was your last complete exam? _____
4. Are you taking any medications or substances? YES NO
   If yes, please list: _____
5. Do you routinely take health related substances? YES NO
6. Are you allergic to any medications or substances? YES NO
   If yes, please list: _____
7. Do you have any other allergies? YES NO
   If yes, please explain: _____
8. Do you have any problems with penicillin, antibiotics, anesthetics, or other medications? YES NO
9. Are you sensitive to any metals or latex? YES NO
10. Are you pregnant or suspect that you may be? YES NO
11. Do you use any birth control medications? YES NO
12. Have you ever been treated for or been told you might have heart disease? YES NO
13. Do you have a pacemaker, or an artificial heart valve implant? YES NO
14. Have you ever had rheumatic fever? YES NO
15. Are you aware of any heart murmurs? YES NO
16. Do you have high or low blood pressure? YES NO
17. Have you ever had a serious illness or major surgery? YES NO
    If yes, please explain: _____
18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? YES NO
19. Do you have inflammatory diseases, such as arthritis, or rheumatism? YES NO
20. Do you have any artificial joints / prosthesis? YES NO
21. Do you have any blood disorders, such as anemia, or leukemia, etc? YES NO
22. Have you ever bled excessively after being cut or injured? YES NO
23. Do you have any stomach problems? YES NO
24. Do you have any kidney problems? YES NO
25. Do you have any liver problems? YES NO
26. Are you diabetic? YES NO
27. Do you have asthma? YES NO
28. Do you have epilepsy or seizure disorders? YES NO
29. Do you have or have you ever had a venereal disease? YES NO
30. Have you tested HIV positive? YES NO
31. Do you have AIDS? YES NO
32. Have you had or do you test positive for hepatitis? YES NO
33. Do you or have you had T.B.? YES NO
34. Do you smoke, chew, use snuff or any other form of tobacco? YES NO
35. Do you consume alcoholic beverages? YES NO
36. Do you habitually use controlled substances? YES NO
37. Have you had psychiatric treatment? YES NO
38. Have you taken the prescription drug fenfluramine, fenfluramine combined with phen-termine (fen-phen), dexfenfluramine (redux), or other weight loss products? YES NO
39. Do you have any disease or condition not listed? YES NO
    If yes, please explain: _____
40. Is there anything else we should know about your health not on this form? YES NO
41. Would you like to speak with the doctor privately about any problem? YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

COMMENTS

ANEST.

MEDICAL HISTORY

Med. Alert