PATIENT REGISTRATION AND HEALTH HISTORY

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

1

DATE

NAME

SPOUSE

ADDRESS

CITY | STATE | ZIP

HOME PHONE NO. | CELL PHONE NO.

BIRTHDATE | AGE | MALE | FEMALE

MARRIED | SINGLE | DIVORCED | WIDOWED

SOCIAL SECURITY NO.

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DATE

NAME

ADDRESS

CITY | STATE | ZIP

HOME PHONE NO. | CELL PHONE NO.

BIRTHDATE | AGE | MALE | FEMALE

SCHOOL | GRADE

SOCIAL SECURITY NO.

IF YOUR CHILD'S LAST NAME AND ADDRESS ARE NOT THE SAME AS YOURS, PLEASE FILL IN THE TOP BOX ALSO

DENTAL INSURANCE **2**

PRIMARY CARRIER

INSURANCE COMPANY

GROUP NO.

EMPLOYEE

DATE OF BIRTH | DATE EMPLOYED

UNION OR LOCAL NO.

EMPLOYEE NO.

EMPLOYEE SOCIAL SECURITY NO.

YOUR PREFERENCES **3**

APPOINTMENT TIMES: AM __ PM __

DAY OF WEEK: M __ T __ W __ T __ F __ S __

DO YOU WISH TO RECEIVE APPOINTMENT CONFIRMATIONS AND OFFICE UPDATES BY EMAIL?
YES __ NO __

EMAIL ADDRESS

GETTING TO KNOW YOU **4**

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?

NAME: RELATIONSHIP:

REFERRED TO US BY

YOUR FORMER ADDRESS

CITY | STATE | ZIP

PERSON TO CONTACT FOR EMERGENCY

PHONE NUMBER

ADDRESS

CITY | STATE | ZIP

CLOSEST RELATIVE NOT LIVING WITH YOU

PHONE NUMBER

ADDRESS

CITY | STATE | ZIP

ACCOUNT INFORMATION **5**

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME

RELATIONSHIP TO PATIENT

ADDRESS

CITY | STATE | ZIP

PHONE NO.

YOU

NAME

OCCUPATION

EMPLOYER

BUSINESS ADDRESS | CITY

BUSINESS PHONE NO. | EXT.

YOUR SPOUSE

NAME

OCCUPATION

EMPLOYER

BUSINESS ADDRESS | CITY

BUSINESS PHONE NO. | EXT.

1. Are you having pain or discomfort at this time? ..... ◯ Yes ◯ No
2. Have you been a patient in the hospital during the past two years? ..... ◯ Yes ◯ No
3. Have you been under the care of a medical doctor during the past two years? ..... ◯ Yes ◯ No

   Physician's Name _____

   Address _____ Telephone _____
4. Have you taken any medication or drugs during the past two years? ..... ◯ Yes ◯ No
5. Are you now taking any medication, drugs or pills? ..... ◯ Yes ◯ No

   If yes, please list: _____
6. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? ..... ◯ Yes ◯ No

   If yes, please list: _____
7. Indicate which of the following you have had or have at present. Mark 'yes' or 'no' to each item.

Heart Failure..... ◯ Yes ◯ No	Stroke..... ◯ Yes ◯ No	Hepatitis A (infectious)..... ◯ Yes ◯ No
Heart Disease or Attack..... ◯ Yes ◯ No	Artificial Joints (hip,knee,etc.). ◯ Yes ◯ No	Hepatitis B (serum)..... ◯ Yes ◯ No
Angina Pectoris..... ◯ Yes ◯ No	Kidney Trouble..... ◯ Yes ◯ No	Venereal Disease..... ◯ Yes ◯ No
Congenital Heart Disease.... ◯ Yes ◯ No	Ulcers..... ◯ Yes ◯ No	A.I.D.S. ..... ◯ Yes ◯ No
Heart Murmur..... ◯ Yes ◯ No	Diabetes..... ◯ Yes ◯ No	H.I.V. Positive ..... ◯ Yes ◯ No
High Blood Pressure..... ◯ Yes ◯ No	Thyroid Problems..... ◯ Yes ◯ No	Cold Sores/Fever Blisters. ◯ Yes ◯ No
Arteriosclerosis..... ◯ Yes ◯ No	Glaucoma..... ◯ Yes ◯ No	Blood Transfusion..... ◯ Yes ◯ No
Mitral Valve Prolapse..... ◯ Yes ◯ No	Cosmetic Surgery..... ◯ Yes ◯ No	Hemophilia..... ◯ Yes ◯ No
Artificial Heart Valve..... ◯ Yes ◯ No	Emphysema..... ◯ Yes ◯ No	Anemia..... ◯ Yes ◯ No
Heart Pacemaker..... ◯ Yes ◯ No	Chronic Cough..... ◯ Yes ◯ No	Sickle Cell Disease..... ◯ Yes ◯ No
Heart Surgery..... ◯ Yes ◯ No	Tuberculosis..... ◯ Yes ◯ No	Bruise Easily..... ◯ Yes ◯ No
Rheumatic Fever..... ◯ Yes ◯ No	Asthma..... ◯ Yes ◯ No	Liver Disease..... ◯ Yes ◯ No
Arthritis..... ◯ Yes ◯ No	Hay Fever..... ◯ Yes ◯ No	Yellow Jaundice..... ◯ Yes ◯ No
Rheumatism..... ◯ Yes ◯ No	Allergies or Hives..... ◯ Yes ◯ No	Epilepsy or Seizures..... ◯ Yes ◯ No
Pain in Jaw Joints..... ◯ Yes ◯ No	Sinus Trouble ..... ◯ Yes ◯ No	Fainting or Dizzy Spells..... ◯ Yes ◯ No
Cortisone Medicine..... ◯ Yes ◯ No	Radiation Therapy..... ◯ Yes ◯ No	Nervousness..... ◯ Yes ◯ No
Drug Addiction..... ◯ Yes ◯ No	Chemotherapy..... ◯ Yes ◯ No	Psychiatric Treatment..... ◯ Yes ◯ No

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?..... ◯ Yes ◯ No
9. Do your ankles swell during the day?..... ◯ Yes ◯ No
10. Do you use more than two pillows to sleep? ..... ◯ Yes ◯ No
11. Have you lost or gained more than 10 pounds in the past year? ..... ◯ Yes ◯ No
12. Do you ever wake up from sleep and feel short of breath? ..... ◯ Yes ◯ No
13. Are you on a special diet?..... ◯ Yes ◯ No
14. Has your medical doctor ever said you have a cancer or tumor? ..... ◯ Yes ◯ No
15. Do you have or have you had any disease, condition, or problem not listed? ..... ◯ Yes ◯ No

    If yes, please list: _____

FOR WOMEN ONLY:

Are you pregnant? □ Yes, what month? _____ □ No Are you nursing? □ Yes □ No Are you 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 truthfully and to the best of my knowledge.

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 in connection with (name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. 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 1 1/2% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtnedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Adult Patient Signature _____ Date _____

Patient or Responsible Party _____ Relationship to Patient _____

Last Dental Appt _____ Last Cleaning_____

Last X-Ray; Panoramic _____ BiteWings _____ Xrays Sent _____

*Insurance coverage may limit frequency of cleaning and x-rays. Patients are encouraged to verify policy benefits before services are rendered.