PATIENT REGISTRATION AND HEALTH HISTORY

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

	_					
		DATE			1	
IF THIS APPOINTMENT IS FOR YOU START HERE		NAME				
		SPOUSE				
		ADDRESS				
		CITY		STATE	ZIP	
		HOME PHONE NO.		CELL PHONE NO.		
		BIRTHDATE	AGE	MALE	FEMALE	
		MARRIED	SINGLE	DIVORCED	WIDOWED	
		SOCIAL SECURITY NO.				
		DATE				
		NAME				
		ADDRESS				
IF THIS APPOINTMENT		CITY		STATE	ZIP	
IS FOR YOUR CHILD START HERE		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				

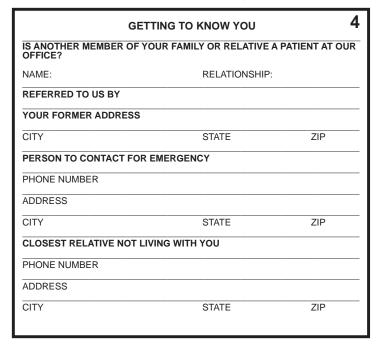
	DENTAL INSURANCE 2						
PRIMARY CARRIER							
	INSURANCE COMPANY						
	GROUP NO.						
	DATE OF BIRTH	DATE EMPLOYED					
	UNION OR LOCAL NO.						
	EMPLOYEE NO.						
EMPLOYEE SOCIAL SECURITY NO.							



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

ACCOU	NT INFOR	RMATION		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.		





	ne?				
2. Have you been a patient in the hospital during the past two years?					
3. Have you been under the care of a medical doctor during the past two years?					
Physician's Name					
Address	Telephone				
4. Have you taken any medication or drugs du	uring the past two years?	Yes () No			
	or pills?				
		0 0			
	ou ever reacted adversely to any medication or substanc	e? Yes () No			
, , ,					
7. Indicate which of the following you have har Heart Failure Yes No	d or have at present. Mark 'yes' or 'no' to each item.	patitis A (infectious) Yes No			
Heart Disease or Attack Yes No		patitis B (serum) Yes No			
Angina Pectoris Yes No		nereal Disease Yes No			
Congenital Heart Disease Yes No		D.S Yes 💍 No			
Heart Murmur Yes No		V. Positive Yes No			
High Blood Pressure Yes No		d Sores/Fever Blisters. Yes No			
Arteriosclerosis		od Transfusion Yes No			
Mitral Valve Prolapse Yes No Artificial Heart Valve Yes No		mophilia Yes () No emia Yes () No			
Heart Pacemaker Yes No		kle Cell Disease Yes No			
Heart Surgery Yes No		ise Easily Yes O No			
Rheumatic Fever Yes No		er Disease Yes O No			
Arthritis Yes No		low Jaundice Yes No			
Rheumatism Yes No Pain in Jaw Joints Yes No		lepsy or Seizures Yes ○ No nting or Dizzy Spells Yes ○ No			
Cortisone Medicine		vousness Yes No			
Drug Addiction Yes No		vchiatric Treatment Yes No			
	you ever have to stop because of pain in your chest, short				
9. Do your ankles swell during the day?		Yes \(\) No			
10. Do you use more than two pillows to sleep?	·	Yes O No			
11. Have you lost or gained more than 10 poun	ds in the past year?	Yes O No			
12. Do you ever wake up from sleep and feel sl	nort of breath?	Yes O No			
13. Are you on a special diet?					
	e a cancer or tumor?	9 9			
•	condition, or problem not listed?	9 9			
FOR WOMEN ONLY:					
	? □ No Are you nursing? □ Yes □ No Are you to	aking birth control pills? □ Yes □ No			
	y to provide me with dental care in a safe and efficient ma				
ruthfully and to the best of my knowledge.	•	•			
CONSENT:					
The undersigned hereby authorizes Doctor	to take X-rays, study models, photographs, or any other di	agnostic aids deemed appropriate			
by Doctor to make a thorough diagnosis of t	he patient's dental needs. I also authorize Doctor to perfo ed in connection with (name of Patient)	orm any and all forms of treatment, and			
further authorize and consent that Doctor ch	noose and employ such assistance as deemed fit. I also u	nderstand the use of anesthetic			
	d that responsibility for payment for Dental Services provide				
	time services are rendered unless financial arrangements 8% annually) will be added to any balance over 60 days. I				
promise to pay legal interest on the indebtne	edness, together with such collection costs and reasonable				
to effect collection of this note.					
	Date				
Patient or Responsible Party	Relationship	to Patient			
Last Dental Appt					
Last X-Ray; Panoramic	BiteWings				
*Insurance coverage may limit frequency of	cleaning and x-rays. Patients are encouraged to verify pe	olicy benefits before services are			

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