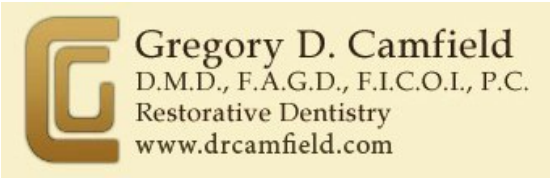

PATIENT INFORMATION

FIRST NAME_____MI_____LAST NAME_____

SEX_____AGE_____BIRTHDATE_____SOC. SEC.#_____MARITAL STATUS: M D S W

HOME ADDRESS_____CITY_____ZIP_____

CELL PHONE_____HOME PHONE_____EMAIL_____

EMPLOYER_____OCCUPATION_____

BUSINESS ADDRESS_____CITY_____ZIP_____

BUSINESS PHONE_____

PERSON TO CONTACT IN CASE OF EMERGENCY_____PHONE_____

RELATIONSHIP_____

ACCOUNT INFORMATION

PREFERRED METHOD OF PAYMENT? CASH____ Check_____ MC/VISA_____

____CHECK HERE IF PERSON ABOVE IS RESPONSIBLE FOR ACCOUNT, IF SAME SKIP TO NEXT SECTION.

PERSONS RESPONSIBLE FOR ACCOUNT PAYMENT: NAME_____ADDRESS_____

_____CITY_____STATE_____ZIP_____

PHONE_____RELATIONSHIP TO PATIENT_____SOC. SEC.#_____

INSURANCE INFORMATION

NAME OF INSURED_____SOC. SEC. #_____RELATIONSHIP TO PATIENT_____

PRIMARY INS. CARRIER CO._____INS. CO. PHONE_____GROUP #_____

POLICY#_____EMPLOYER_____DATE EMPLOYED_____EMPLOYER

ADDRESS_____CITY_____STATE_____ZIP_____

DUAL COVERAGE Y OR N?

SECONDARY INS. CO._____ INS.CO.PHONE_____GROUP#_____

POLICY#_____EMPLOYER_____DATE EMPLOYED_____EMPLOYER

ADDRESS_____CITY_____STATE_____ZIP_____

I authorize the release of any information necessary to process my insurance claim. I also authorize payment to the dentist of the insurance benefits otherwise payable to me. A copy of this signature is as valid as original.X_____

HEALTH HISTORY

To our patients: Although dentists primarily treat the area in and around your mouth, your mouth is a part of your body, especially your digestive system. Health problems that you may have or medications that your may be taking could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Reason for today's visit?_____

Are you in good health?_____Height_____Weight_____
Have there been any changes in your general health in the past year?_____
Are you under the care of a physician?_____If so who?_____What are they treating you for?_____Date of last visit_____
Have you had any illness, operation or been hospitalized in the last 5 years?_____
Do you have any unhealed/ recurrent injuries or inflamed areas, growths or sore spots in and around your mouth?_____
If so where?_____
Do you have any prosthetic joints or implants?_____If so where?_____
Have you had a heart valve replacement or vascular graft?_____If so when?_____
Who is your Cardiologist?_____ Phone #_____

HAVE YOU HAD OR DO YOU CURRENTLY HAVE…..

NOTES

1. Rheumatic fever? Y / N
2. Damaged heart valve? Y / N
3. Mitral valve prolapse? Y / N
4. Heart murmur? Y / N
5. High blood pressure? Y / N
6. Low blood pressure? Y / N
7. Chest pain/angina? Y / N
8. Heart attack(s)? Y / N
9. Irregular Heart beat? Y / N
10. Pacemaker? Y / N
11. Heart surgery? Y / N
12. Bronchitis? Y / N
13. Chronic cough? Y / N
14. Asthma? Y / N
15. Hay fever? Y / N
16. Sinus infections? Y / N
17. Snoring? Apnea? Y / N
18. Lung problems? Y / N
19. Tuberculosis? Y / N
20. Emphysema? Y / N
21. Do you smoke? Y / N
22. Use chewing tobacco? Y/ N

NOTES

23. Blood transfusions? Y / N
24. Blood disorders? Y / N
25. Anemia? Y / N
26. Bruise easily? Y / N
27. Abnormal bleeding? Y / N
28. Hepatitis? Y / N
29. Liver disease? Y / N
30. Mononucleosis? Y / N
31. Gallbladder trouble? Y / N
32. Fainting spells? Y / N
33. Epilepsy? Y / N
34. Stroke? Y / N
35. Thyroid trouble? Y / N
36. Diabetes? Y / N
37. Low blood sugar? Y / N
38. Kidney trouble? Y / N
39. Are you on dialysis? Y / N
40. Arthritis, joint disease? Y / N
41. Stomach ulcers? Y / N
42. Acid reflux, GERD? Y / N
43. STD's ? Y / N
44. HIV? Y / N

HEALTH HISTORY (continued)

45. Are you immunosuppressed? (possibly from transplant surgery, chemotherapy, etc.) Y / N
46. Delay in healing? Y / N
47. Tumors or growth? Y / N
48. Radiation therapy? Y / N
49. Special diet? Y / N
50. History of drug abuse? Y / N
51. History of alcohol abuse? Y/N
52. Eating disorder? Y / N
54. Mental health problems? Y / N

55. DO YOU HAVE ANY OTHER DISEASE, CONDITION, OR PROBLEM NOT LISTED ABOVE? IF YES PLEASE EXPLAIN?

_____
_____
_____
_____
_____
_____
_____

ALLERGIES Are you allergic to, or had a reaction to……..

55. Any kind of medication, drug, pill? Y / N
56. Local anesthetic (numbing med.)? Y / N

57. Circle if allergic to any of the following:

Penicillin Sulfa Aspirin Ibuprofen

Clindamycin Codeine Vicocdin NSAIDS

Erythromycin Tylenol Acetaminophen

Citanest Mepivicaine Lidocaine

Other_____

58. Latex? Y / N
59. Food allergies? Y / N

If yes please list:

_____
_____
_____
_____

MEDICATION Are you taking….

NOTES

60. Any kind of medication, drugs, pills? Y / N
61. Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko Bilboa)? Y / N
62. Any bone density medications/Biphosphonates (Aredia, Zometa, Fosamax, Actonel) ? Y / N

Please list any medications you are currently taking:

_____
_____
_____

WOMEN ONLY:

63. Is there a possibility of pregnancy? Y / N
64. Expected delivery date _____/_____/_____
65. Are you nursing? Y / N
66. Birth control or Hormones? Y / N

If yes please list:_____

Women Note: *Antibiotics(such as penicillin may alter the effectiveness of birth control pills.Consult your physician / gynecologist for assistance regarding additional methods of birth control.*

DENTAL HISTORY

1. Are you having any discomfort with your teeth or mouth at this time? _____Yes_____No
   Describe:_____
   _____
   _____
2. How long has it been since your last dental visit?_____
3. Does dental treatment make you nervous?_____No_____Slightly____Moderately_____Extremely
4. How frequently do you brush your teeth?_____
5. How frequently do you floss your teeth?_____
6. Do you use any mouth rinses? _____Yes_____No
7. Do you wear a guard at night to protect your teeth?_____Yes_____No
8. Do you use a prescription strength fluoride toothpaste or rinse?_____Yes_____No
9. When was the last time you had dental x-rays?_____

Previous Dentist's Name:_____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (PLEASE CIRCLE)

Bleeding / Sore Gums	Loose Teeth	Gum treatment	Cold /Hot Sensitive Teeth
Unpleasant Taste	Bad Breath	Burning tongue	Blisters
Swelling in Mouth	Jaw Fractures	Broken Teeth	Clenching or Grinding
Jaw Pain	Jaw Surgery	Jaw Popping	Jaw Clicking
"TMJ"	Ear pain	Neck Pain	Frequent Headaches
Muscle soreness in Jaw	Root Canals	Dental Implants	Full Dentures
Orthodontic Treatment	Partial Dentures	Crowns	Bridges
Food Traps	Oral Surgery	Missing teeth	Sensitivity to Sweets
Gum Surgery	Bite Treatments		

OUR OFFICE POLICIES

We have three policies we feel are important to share with our patients. We strongly believe in our work and professional efforts. We, therefore, ask you to read this page thoroughly, and then sign indicating that your understand these policies.

COMMITMENT TO TREATMENT POLICY….

We believe that all treatment begun should be completed. Incomplete treatment leads to problems, complications, misunderstandings and usually further disease. Therefore, if a plan is agreed upon and started, it needs to be completed.

COMMITMENT TO APPOINTMENT POLICY….

Time has become one of our most valuable commodities in today's world. We realize how important time is to you. We limit the number of patients we see in a day. When we place your name on our schedule and reserve a block of time for you, we trust that you will be here for that appointment. We request that you give us at least 24 hours notice prior to canceling an appointment. We constantly strive to be on time for your appointment. However, patients with emergencies sometimes need our attention and we will handle them in the absolute minimum amount of time possible.

COMMITMENT TO FINANCIAL ARRANGEMENT POLICY……

We believe we have the responsibility to use the best professional care, skill and judgment in planning and delivering your dental treatment. Your payment will reimburse us for our services. By signing below, you are indicating that after all fees are properly explained to you, you agree to fulfill your financial commitment to our office promptly and completely.

TREATMENT AUTHORIZATION AND ACKNOWLEDGEMENT…..

I consent to examination as necessary or desirable to the care of the registered patient, for the diagnosis of dental disease, deformity, or treatment of dental emergency. The procedures may include radiographs, models photographs and intraoral exams. In case of dental emergency, I consent to treatment as deemed necessary by the doctor, understanding that procedures will be explained in advance. I have read and completed the following questionnaires to the best of my knowledge and agree to the above policies.

X_____Date_____