

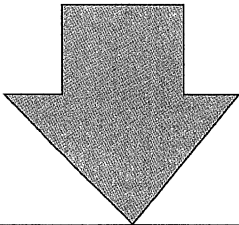
PATIENT REGISTRATION AND HEALTH HISTORY

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION



1			
DATE			
NAME			
SPOUSE			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			
DATE			
NAME			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL	GRADE		
SOCIAL SECURITY NO.			
IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO			

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



4	
ACCOUNT INFORMATION	
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.

3	
GETTING TO KNOW YOU	
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



- Are you having pain or discomfort at this time?.....YES NO
- Have you been a patient in the hospital during the past two years?YES NO
- Have you been under the care of a medical doctor during the past two years?.....YES NO

Physician's Name _____ Phone No. _____
 Address _____

- Have you taken any medication or drugs during the past two years?YES NO
- Are you now taking any medication, drugs or pills?YES NO

If yes, please list: _____

- 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. Circle "yes" or "no" to each item.

Heart Failure.....YES NO	Artificial Joints (hip, knee, etc.)....YES NO	Hepatitis B (serum).....YES NO
Heart Disease or Attack.....YES NO	Kidney TroubleYES NO	Venereal DiseaseYES NO
Angina Pectoris.....YES NO	UlcersYES NO	A.I.D.S.YES NO
Congenital Heart Disease.....YES NO	DiabetesYES NO	H.I.V. PositiveYES NO
Heart Murmur.....YES NO	Thyroid ProblemsYES NO	Cold Sores/Fever Blisters.....YES NO
High Blood Pressure.....YES NO	GlaucomaYES NO	Blood Transfusion.....YES NO
ArteriosclerosisYES NO	Cosmetic SurgeryYES NO	Hemophilia.....YES NO
Mitral Valve Prolapse.....YES NO	Emphysema.....YES NO	AnemiaYES NO
Artificial Heart ValveYES NO	Chronic Cough.....YES NO	Sickle Cell Disease.....YES NO
Heart Pacemaker.....YES NO	TuberculosisYES NO	Bruise Easily.....YES NO
Heart SurgeryYES NO	AsthmaYES NO	Liver Disease.....YES NO
Rheumatic FeverYES NO	Hay FeverYES NO	Yellow Jaundice.....YES NO
Arthritis.....YES NO	Allergies or Hives.....YES NO	Epilepsy or Seizures.....YES NO
Rheumatism.....YES NO	Sinus TroubleYES NO	Fainting or Dizzy SpellsYES NO
Cortisone MedicineYES NO	Radiation TherapyYES NO	Nervousness.....YES NO
Drug AddictionYES NO	Chemotherapy.....YES NO	Psychiatric Treatment.....YES NO
StrokeYES NO	Hepatitis A (infectious).....YES NO	Developmentally DisabledYES NO

- 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

- Do your ankles swell during the day?.....YES NO

- Do you use more than two pillows to sleep?YES NO

- Have you lost or gained more than 10 pounds in the past year?YES NO

- Do you ever wake up from sleep and feel short of breath?YES NO

- Are you on a special diet?YES NO

- Has your medical doctor ever said you have a cancer or tumor?YES NO

- 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
 Have you ever taken prescription medications for weight loss (diet pills)? Yes No
 If yes, did you take any of the following: Yes No Fen-Phen (Fenfluramine-Phenpermine)
 Yes No Pondimin (Fenfluramine)
 Yes No Redux (Dexfenfluramine)

If yes to any of the above, did you have a medical exam for heart issues? 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.

Patient Signature _____ Date _____

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 all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____ I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
- Lastly, I understand that all 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 other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____