

Welcome to our practice! Dental care is more than repair. Our intention is to assist you in gaining and maintaining your best dental health. This includes: 1) restoring your teeth so that they are comfortable, functional and attractive; 2) treating your gum tissue so that your “dental machine” can last your entire life-time; and 3) evaluating your general health and habits that may affect your future dental health.

Your answers to the following questions are the first step in determining your immediate and long-term dental care. Please add any comments you may have...the more we know about your needs and concerns, the better we can serve you. Thank you!

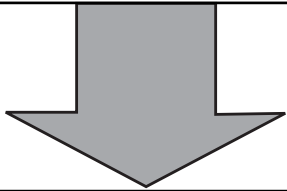


DATE			
FIRST NAME		LAST NAME	
NAME YOU WISH TO BE CALLED			
HOME ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.		CELL NO.	
EMAIL			
BIRTHDATE		AGE	
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			
SPOUSE		SPOUSE OCCUPATION	



DATE			
NAME			
NAME YOU WISH TO BE CALLED			
HOME ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.		CELL NO.	
BIRTHDATE	AGE	GRADE	
SCHOOL			
IF YOUR CHILD'S NAME AND ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE ABOVE BOX ALSO.			

<b>DENTAL INSURANCE</b>	
<b>PRIMARY CARRIER</b>	
INSURANCE COMPANY	
NAME OF INSURED	
DATE OF BIRTH OF INSURED	
SOCIAL SECURITY # OF INSURED	
EMPLOYER	
GROUP #	
EFFECTIVE DATE	PHONE
<b>SECONDARY CARRIER</b>	
INSURANCE COMPANY	
NAME OF INSURED	
DATE OF BIRTH OF INSURED	
SOCIAL SECURITY # OF INSURED	
EMPLOYER	
GROUP #	
EFFECTIVE DATE	PHONE



<b>ACCOUNT INFORMATION</b>	
<b>PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT</b>	
NAME	
RELATIONSHIP	
SOCIAL SECURITY #	
DRIVERS LICENSE NO.	
BANK	
BRANCH	
ACCOUNT NO.	
OCCUPATION	
EMPLOYER	
BUSINESS ADDRESS	CITY
BUSINESS TELEPHONE	EXT.



<b>GETTING TO KNOW YOU</b>		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS	CITY	
BUSINESS TELEPHONE	EXT.	
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

# HEALTH HISTORY

CIRCLE

1. Are you having pain or discomfort at this time?..... YES NO
2. Do you feel very nervous about having dental treatment?..... YES NO
3. Have you ever had a bad experience in the dental office?..... YES NO
4. Have you been a patient in the hospital during the past two years?..... YES NO
5. Have you been under the care of a medical doctor during the past two years?..... YES NO

Physician's Name \_\_\_\_\_

Address \_\_\_\_\_ Phone# \_\_\_\_\_

6. Have you taken any medicine or drugs during the past two years?..... YES NO
7. Are you now taking any medication, drugs or pills?..... YES NO
8. Are you aware or being allergic to or have you ever reacted adversely to any medicatin or substance such as Latex or local anesthetic?..... YES NO

if yes, please list: \_\_\_\_\_

9. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

- |   |   |                                      |
|---|---|--------------------------------------|
| Heart Failure..... YES NO                 | Emphysema..... YES NO                   | Hepatitis (type _____)..... YES NO   |
| Heart Disease or Attack..... YES NO       | Cough, persistent or bloody..... YES NO | Headaches..... YES NO                |
| Angina Pectoris..... YES NO               | Tuberculosis (TB)..... YES NO           | Liver Disease..... YES NO            |
| High Blood Pressure..... YES NO           | Asthma..... YES NO                      | Yellow Jaundice..... YES NO          |
| Heart Murmur..... YES NO                  | Hay Fever..... YES NO                   | Blood Transfusion..... YES NO        |
| Rheumatic Fever..... YES NO               | Sinus Trouble..... YES NO               | Drug Addiction..... YES NO           |
| Congenital Heart Lesions..... YES NO      | Allergies or Hives..... YES NO          | Hemohilia..... YES NO                |
| Scarlet Fever..... YES NO                 | Diabetes..... YES NO                    | Venereal Disease                     |
| Artificial Heart Valve..... YES NO        | Thyroid Disease..... YES NO             | (Syphilis, Gonorrhoea)..... YES NO   |
| Heart Pacemaker..... YES NO               | Chemotherapy (Cancer, Leukemia) YES NO  | Cold Sores..... YES NO               |
| Heart Surgery..... YES NO                 | Arthritis..... YES NO                   | Fever Blisters..... YES NO           |
| Artificial Joints (Hip, Knee)..... YES NO | Rheumatism..... YES NO                  | Epilepsy or Seizures..... YES NO     |
| Anemia..... YES NO                        | Cortisone Medicine..... YES NO          | Fainting or Dizzy Spells..... YES NO |
| Stroke..... YES NO                        | Glaucoma..... YES NO                    | Nervousness..... YES NO              |
| Kidney Trouble..... YES NO                | Pain in Jaw Joints..... YES NO          | Psychiatric Treatment..... YES NO    |
| Ulcers..... YES NO                        | HIV Positive or Aids..... YES NO        | Sickle Cell Disease..... YES NO      |
| Cosmetic Surgery..... YES NO              | Herpes..... YES NO                      | Bruise Easily..... YES NO            |
| Mitral Valve Prolapse..... YES NO         |   |                                      |

10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired?..... YES NO
11. Do your ankles swell during the day?..... YES NO
12. Have you ever taken Fen-Phen or Redux?..... YES NO
13. Have you lost or gained more than 10 pounds in the past?..... YES NO
14. Do you ever wake up from sleep short of breath?..... YES NO
15. Are you on a special diet?..... YES NO
16. Has your medical doctor ever said you have a cancer or tumor?..... YES NO
17. Do you have any disease, condition, or problem not listed?..... YES NO
18. Do you smoke?..... YES NO

if yes, how much? \_\_\_\_\_

## FOR WOMEN ONLY:

Are you pregnant?  Yes  No if yes, what month?\_\_\_\_\_. Are you taking birth control pills?  Yes  No

## 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 that 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 events of default (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. Bad or canceled checks are subject to a \$15.00 administrative fee. Patients with insurance are fully responsible for any charges not covered by their insurance company.

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 \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Parents or Responsible Party \_\_\_\_\_ Relationship to Patient \_\_\_\_\_