PATIENT REGISTRATION AND HEALTH HISTORY

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

DATE			
NAME			
SPOUSE			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE #			
BIRTH DATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY #			

DENTAL INSURANCE
PRIMARY CARRIER
INSURANCE COMPANY
EMPLOYEE
DATE OF BIRTH
GROUP #
UNION OR LOCAL #
DATE EMPLOYED
EMP. SOCIAL SECURITY #

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DATE			
NAME			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE #			
BIRTH DATE	AGE	MALE	FEMALE
SCHOOL			GRADE
IF YOURCHILD'S LAST NAME AND /OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO.			

SECONDARY CARRIER
INSURANCE COMPANY
EMPLOYEE
DATE OF BIRTH
GROUP #
UNION OR LOCAL #
DATE EMPLOYED
EMP. SOCIAL SECURITY #

ACCOUNT INFORMATION		
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
DRIVERS LICENSE #	RELATIONSHIP TO PATIENT	
BANK		
BRANCH		
ACCOUNT #		
YOU		
NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS	CITY	
BUSINESS TELEPHONE	EXT	
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS	CITY	
BUSINESS TELEPHONE	EXT	

GETTING TO KNOW YOU		
IS ANOTHER MEMBER OF YOUR FAMILY OR AT OUR OFFICE? THEIR NAME -		
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

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. Circle "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,ect.)	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? _____ 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.

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 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 indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient Signature Date

Parent or responsible Party Relationship to patient