PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

	DATE				DENTA	LINSURANCE	2				
<u> </u>	LAST NAME FIRST M.I.						PRIMARY CARRIER				
	PREFERS TO BE	CALLED BY					INSURANCE COMPAN	1Y			
IFTHIS	ADDRESS						GROUP NO.				
APPOINTMENT	CITY		STATE	ZIP			EMPLOYER NAME				
START HERE	HOME PHONE N	0.	FAX				INSURED'S NAME				
	CELL	CELL EMAIL					DATE OF BIRTH	RELATIONSHIP TO PA	TIENT		
	BIRTHDATE	AGE	MALE	FE	EMALE	Λ.	INSURED'S I.D. NO.				
	MARRIED	SINGLE	DIVORCED	W	IDOWED		INSURED'S SOCIAL S	SECURITY NO.			
	SOCIAL SECURI	TY NO.	1				SECONDARY CARRIER				
	DATE					7/	INSURANCE COMPAN				
	LAST NAME	FIRS	ST		M.I.	V	GROUP NO.				
	ADDRESS			_			EMPLOYER NAME				
APPOINTMENT IS	CITY		STATE		ZIP		INSURED'S NAME				
FOR YOUR CHILD START HERE	HOMEPHONEN	0	STATE		211		DATE OF BIRTH	DEL ATIONSHIP TO DA	TIENT		
JIAM TERE		7				INSURED'S I.D. NO.	RELATIONSHIP TO PATI				
	BIRTHDATE	AGE	MALE		EMALE			SECURITY NO			
,	SCHOOL			(GRADE		INSURED'S SOCIAL S	BECORITY NO.			
	SOCIAL SECURIT	TY NO.									
	IF YOUR CHILD'S LAST	NAME AND/OR ADDRESS	ARE NOT THE SAMI	E AS YO	URS, FILL IN THE TOP BO	X ALSO					
	ACCOUNT INF	ORMATION	4								
PERSON FINA	NCIALLY RES	PONSIBLE FOR	ACCOUNT								
NAME											
RELATIONSHIP TO	PATIENT	SOCIAL SECURITY I	NO.								
ADDRESS						GET	TING TO KNOW Y	OU	3		
CITY	STAT	E ZIP			IS ANOTHER MEN AT OUR OFFICE?		OUR FAMILY OR RELA	TIVE A PATIENT			
PHONE NO.					NAME:						
V011					RELATIONSHIP:						
YOU					YOU WERE REFE	RRED TO U	SBY				
OCCUPATION											
					NAME:	Phartele					
EMPLOYER'S NAME					PERSON TO CONTACT FOR EMERGENCY						
ADDRESS CITY					NAME:						
PHONE NO. FAX NO.					CELL NUMBER						
YOUR SPOUS	E			N	HOME NUMBER						
NAME					ADDRESS						
OCCUPATION					CITY		STATE	ZIP			
EMPLOYER'S NAM	1E						STATE	211			
ADDRESS		CITY									
PHONE NO.		FAX NO.									

CONSENT FOR TREATMENT

	Party's Signature Relationship to Patient
N	My cell phone number is (include area code)
	nsurance, and my account. I understand that I can withdraw my consent at any time.
	one or both) a call or a text regarding appointments and to call regarding treatment,
6 (Cell Phone: I consent to the dental practice using my cell phone number to (choose
	account. If required, I also understand a check of my credit history may be made.
	arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my
	dependents. I understand that payment is due at the time of service unless other
	agree to be responsible for payment of all services rendered on my behalf or my
F	personal health information is available.
(care will be used or disclosed and that a notice fully outlining the protection of my
,	understand that only the minimum amount of information necessary to provide quality
	written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I
	give consent to the doctor's or designated staff's use and disclosure of any oral,
	can ask for a complete recital of any possible complications.
	agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I
2 1	
	proper care.
	mutually agreed upon by me and to employ such assistance as required to provide
2 1	Jpon such diagnosis, I authorize doctor to perform all recommended treatment
`	of (name of patient)'s dental needs.

Patient Account No.

Medical Alert

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

Biting or Chewing?	Date of Last Dental Visit	Last Dental Cleaning	l	Last Full Mouth X-rays					
Address State Zip How often do you brush your teeth? How often do you floss? How often do you brush your teeth? How often do you floss? Have you ever used or are currently using topical fluoride? Yes No What other dental aids do you use? (Interplak, toothpick, etc.) Do you have any dental problems now? Yes No If yes, please describe: Are any of your teeth sensitive to: Hot or cold? Yes No Oral Surgery? Yes No Sweets? Yes No Oral Surgery? Yes No Have you noticed any mouth odors or bad tastes? Yes No Periodontal treatment? Yes No Your feeth ground or the bite adjusted? Yes No Do your feeuwently get cold sores, blisters or any other oral lesions? Yes No A senious injury to the mouth or head? Yes No Have your parents experienced gum disease or tooth loss? Yes No Have your noticed any loose teeth or change in your bite? Yes No Does stood tend to become caught in between your teeth? Yes No Do you: Clerch or grind your teeth while awake or asleep? Yes No Hold foreign objects with your teeth? (pencils, pipe, etc.) Mouth breathe while awake or asleep? Yes No Sorie muscles (neck, shoulders)? Yes No Are you satisfied with your teeth's appearance? Yes No Smokeichew tobacco or use other tobacco products? Yes No Do you feel nervous about having dental treatment? Yes No Please describe Have you ever had an upsetting dental experience? Yes No Please describe Have you ever had an upsetting dental experience? Yes No Please describe Have you ever been told to take a pre-medication prior to dental treatment? Yes No	What was done at your last dental visit?								
How often do you have dental examinations? How often do you brush your teeth? How often do you floss? Have you ever used or are currently using topical fluoride? Yes No What other dental aids do you use? (Interplak, toothpick, etc.) Do you have any dental problems now? Yes No If yes, please describe: Are any of your teeth sensitive to: Hot or cold? Yes No Oral Surgery? Yes No Billing or Chewing? Yes No Oral Surgery? Yes No Have you ever had: How you noticed any mouth odors or bad tastes? Yes No Your feeth ground or the bite adjusted? Yes No Do your fequently get cold sores, blisters or any other oral lesions? Yes No Abite plate or mouth guard? Yes No Have your prents experienced gum disease or tooth loss? Yes No Have your prents experienced gum disease or tooth loss? Yes No Have your noticed any losse teeth or change in your bite? Yes No Do you: Cliench or grind your teeth while awake or asleep? Yes No Have your prents experienced with your teeth? Yes No Have your prents experienced prent in between your teeth? Yes No Do you: Cliench or grind your teeth while awake or asleep? Yes No Have the while awake or asleep? Yes No Have the doffence objects with your teeth? (pencils, pipe, etc.) Mouth breathe while awake or asleep? Yes No Have the while awake or asleep? Yes No Have the while awake or asleep? Yes No Have the while awake or asleep? Yes No Mould you like to replace your silver fillings? Yes No Sore muscles (neck, shoulders)? Yes No Nould you like to keep all of your teeth all of your life? Yes No Novel the neon the your teeth all of your life? Yes No Novel you feel nervous about having dental treatment? Yes No Please describe Have you ever had an upsetting dental experience? Yes No Please describe Have you ever had an upsetting dental experience? Yes No Please describe Have you ever had an upsetting dental experience? Yes No Novel you wer been told to take a pre-medication prior to dental treatment? Yes No Novel you wer been told to take a pre-medication prior to dental treatment? Yes No Novel you wer be	Previous Dentist's Name			Telephone					
How often do you brush your teeth? Have you ever used or are currently using topical fluoride? Yes No What other dental aids do you use? (Interplak, toothpick, etc.) Do you have any dental problems now? Yes No If yes, please describe: Are any of your teeth sensitive to: Hot or cold? Yes No Orhodontic treatment? Yes No Oral Surgery? Yes No Periodontal treatment? Yes No Periodontal treatment? Yes No Periodontal treatment? Yes No Your teeth ground or the bite adjusted? Yes No Your teeth ground or the bite adjusted? Yes No A bite plate or mouth guard? A serious injury to the mouth or head? Yes No Have you noticed any mouth odors or bad tastes? Yes No A bite plate or mouth guard? A serious injury to the mouth or head? Yes No Have you prarents experienced gum disease or tooth loss? Yes No Have you noticed any loose teeth or change in your bite? Yes No Clicking or popping of the jaw? Yes No Have you experienced If yes, where Do you: Do you: Do you: Do you: Do you: Do you: Do you frequently get cold sores, blisters or any other oral lesions? Yes No Have you parents experienced gum disease or tooth loss? Yes No Have you experienced gum disease or tooth loss? Yes No Have you noticed any loose teeth or change in your bite? Yes No Clicking or popping of the jaw? Yes No Have you experienced? Yes No Clicking or popping of the jaw? Yes No Headaches, neckaches or shoulder achees? Yes No Headaches, neckaches or shoulder achees? Yes No Mouth breathe while awake or asleep? Yes No Green used (inck, shoulders)? Yes No Sore musdes (neck, shoulders)? Yes No Sore musdes (neck, shoulders)? Yes No Would you like to keep all of your teeth's appearance? Yes No Would you like to keep all of your teeth all of your life? Yes No Would you like to keep all of your teeth's appearance? Yes No Would you like to keep all of your teeth's appearance? Yes No Would you like to keep all of	Address			State Zip					
How often do you brush your teeth? Have you ever used or are currently using topical fluoride? Yes No What other dental aids do you use? (Interplak, toothpick, etc.) Do you have any dental problems now? Yes No If yes, please describe: Are any of your teeth sensitive to: Hot or cold? Yes No Orhodontic treatment? Yes No Oral Surgery? Yes No Periodontal treatment? Yes No Periodontal treatment? Yes No Periodontal treatment? Yes No Your teeth ground or the bite adjusted? Yes No Your teeth ground or the bite adjusted? Yes No A bite plate or mouth guard? A serious injury to the mouth or head? Yes No Have you noticed any mouth odors or bad tastes? Yes No A bite plate or mouth guard? A serious injury to the mouth or head? Yes No Have you prarents experienced gum disease or tooth loss? Yes No Have you noticed any loose teeth or change in your bite? Yes No Clicking or popping of the jaw? Yes No Have you experienced If yes, where Do you: Do you: Do you: Do you: Do you: Do you: Do you frequently get cold sores, blisters or any other oral lesions? Yes No Have you parents experienced gum disease or tooth loss? Yes No Have you experienced gum disease or tooth loss? Yes No Have you noticed any loose teeth or change in your bite? Yes No Clicking or popping of the jaw? Yes No Have you experienced? Yes No Clicking or popping of the jaw? Yes No Headaches, neckaches or shoulder achees? Yes No Headaches, neckaches or shoulder achees? Yes No Mouth breathe while awake or asleep? Yes No Green used (inck, shoulders)? Yes No Sore musdes (neck, shoulders)? Yes No Sore musdes (neck, shoulders)? Yes No Would you like to keep all of your teeth's appearance? Yes No Would you like to keep all of your teeth all of your life? Yes No Would you like to keep all of your teeth's appearance? Yes No Would you like to keep all of your teeth's appearance? Yes No Would you like to keep all of	How often do you have dental examinations?								
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Have your parents experienced gum disease or tooth loss?		V	M						
Have you noticed any loose teeth or change in your bite? Yes No Does food tend to become caught in between your teeth? Yes No If yes, where				Please describe, including cause					
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Difficulty in opening or closing the mouth? Yes No Difficulty in chewing on either side of the mouth? Yes No Headaches, neckaches or shoulder aches? Yes No Bite your lips or cheeks regularly? Yes No Sore muscles (neck, shoulders)? Yes No Hold foreign objects with your teeth? (pencils, pipe, etc.) Yes No Mouth breathe while awake or asleep? Yes No Mouth breathe while awake or asleep? Yes No Have tired jaws, especially in the morning? Yes No Would you like to replace your silver fillings? Yes No Smoke/chew tobacco or use other tobacco products? Yes No Do you feel nervous about having dental treatment? Yes No Do you feel nervous about having dental experience? Yes No Please describe Have you ever had an upsetting dental experience? Yes No Please describe Have you ever been told to take a pre-medication prior to dental treatment? Yes No No Headaches, neckaches or shoulder aches? Yes No Sore muscles (neck, shoulders)? Yes No Mould you teeth's appearance? Yes No Would you like to replace your silver fillings? Yes No Would you like to keep all of your teeth all of your life? Yes No No No Would you like to keep all of your teeth all of your life? Yes No	•		N0						
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Bite your lips or cheeks regularly?		V	M-	· · · · · · · · · · · · · · · · · · ·					
Hold foreign objects with your teeth? (pencils, pipe, etc.)	• •								
Mouth breathe while awake or asleep? Yes No Have tired jaws, especially in the morning? Yes No Snore or have any other sleeping disorders? Yes No Smoke/chew tobacco or use other tobacco products? Yes No Do you feel nervous about having dental treatment? Yes No Please describe Have you ever had an upsetting dental experience? Yes No Have you ever been told to take a pre-medication prior to dental treatment? Yes No Have you ever been told to take a pre-medication prior to dental treatment? Yes No No Have you ever been told to take a pre-medication prior to dental treatment? Yes No No No Have you ever been told to take a pre-medication prior to dental treatment? Yes No No No Have you ever been told to take a pre-medication prior to dental treatment? Yes No No No Have you ever been told to take a pre-medication prior to dental treatment? Yes No No No Have you ever been told to take a pre-medication prior to dental treatment? Yes No No No Have you ever been told to take a pre-medication prior to dental treatment?	, ,			,	3 IN				
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Have you ever been told to take a pre-medication prior to dental treatment?	Have you ever had an upsetting dental experience?			Ye:	s N				
Have you ever been told to take a pre-medication prior to dental treatment?	Please describe								
Is there anything else about having dental treatment that you would like us to know?Yes	Have you ever been told to take a pre-medication price	or to dental treatment?		Ye	s N				
	s there anything else about having dental treatme	ent that you would like us	to know?	Ye	s N				

Patient	Name							MEDIC	CAL H	IISTO	ORY
Patient	Account No.				Medical Alert						
1	Physician's Name				Ph	nne ()				
	Have you had any medical care w								No		
2.		-	_							Yes	No
Q	If yes, please list name and dosage Are you currently taking any med	-		nills or herbal remov						Voc	No
٥.	If yes, please list name and dosay		-	pilis of fierbal ferries	_	-	•	•		163	NO
4.	Have you ever taken bone loss pi	•	on drug	s such as Fosamax,	Actonel, Boniv	a or oth	er bispho	sphonates?		Yes	No
	If yes, please list name and dosage										
5.	Are you aware of having an allerg If yes, please specify									Yes	No
6.	Have you been a patient in the ho	spital o	during t	he past five years?						Yes	No
7.	Indicate which of the following yo	u have	had, or	have at present. Se	elect "yes" or "n	o" to ea	ch item.				
	Heart (Surgery, Disease, Atack)	Yes	No	Ulcers		Yes	No	Hepatitis A B C	(Select)	Yes	No
	Chest Pain	Yes	No	Diabetes		Yes	No	Venereal Disease		Yes	No
	Congenital Heart Disease	Yes	No	Thyroid Problems	S	Yes	No	A.I.D.S./H.I.V. Positive .		Yes	No
	Heart Murmur	Yes	No	Glaucoma		Yes	No	Cold Sores/Fever Bliste	ers	Yes	No
	High/Low Blood Pressure	Yes	No	Contact lenses			No	Blood Transfusion			No
	Mitral Valve Prolapse	Yes	No	Emphysema			No	Hemophilia			No
	Artificial Heart Valve/Pacemaker		No	Chronic Cough			No	Sickle Cell Disease			No
	Rheumatic Fever	Yes	No	Tuberculosis			No	Bruise Easily			No
	Arthritis/Rheumatism	Yes	No	Asthma			No	Liver Disease/Yellow Ja			No
	Cortisone Medicine		No	Hay Fever/Allergy			No	Neurological Disorders			No
	Swollen Ankles		No	Latex Sensitivity			No	Epilepsy or Seizures			No
	Stroke	Yes	No	Sinus Trouble			No	Fainting or Dizzy Spells			No
	Diet (Special/Restricted)		No No	Radiation Therapy			No No	Nervous/Anxious			No
	Artificial Joints (hip, knee, etc.) Kidney Trouble		No No	Chemotherapy Tumors			No No	Psychiatric/Psychologicancer			No No
8.	Have you lost or gained more tha	n 10 po	ounds ir	n the past year?						Yes	No
9.	Do you have or have you had any				ot listed?					Yes	No
10	If yes, please list:				/aa N	مطلمما	N.	Nin a 2	v/aa Na		
	Women: Are you pregnant or to you use birth control prescription.									Yes	No
 	understand the above infor answered all questions to th ask the respective health ca any change in my health or i	matic e bes re pro	n is no t of m vider	ecessary to prov y knowledge. Sł or agency, who	vide me with hould further	denta inforn	l care ir nation b	n a safe and efficier be needed, you hav	nt manne e my pe	er. I ha ermissi	ion to
P	atient/Guardian Signature							Date			
H	listory Review										
	Pentist Signature							Date			