Patient Number _____ A B C **HEALTH HISTORY & REGISTRATION**

PATIENT INFORMATION

PATIENT'S NAME Last _____ First _____ Middle Initial _____ Sex: M F BIRTHDATE _____ AGE _____

Soc. Sec. # _____ If Patient is a Minor, give Parent's or Guardian's Name _____ TODAY'S DATE _____

Who May We Thank for Referring You to our Office? _____ Reason for this Visit _____

RESPONSIBLE PARTY INFORMATION

NAME Last _____ First _____ Middle _____ MARITAL STATUS _____

RESIDENCE Street _____ City _____ State _____ Zip _____

MAILING ADDRESS Street _____ City _____ State _____ Zip _____

HOW LONG AT THIS ADDRESS _____ HOME PHONE _____ WORK PHONE _____

PREVIOUS ADDRESS (if less than 3 yrs.) Street _____ City _____ State _____ Zip _____

SOCIAL SECURITY # _____ BIRTHDATE _____ DRIVER'S LICENSE # _____ RELATION TO PATIENT _____

EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____

RESPONSIBLE PARTY'S SPOUSE

NAME _____
LAST FIRST MIDDLE

EMPLOYER _____ NO. YEARS EMPLOYED _____

OCCUPATION _____ SOC. SEC. # _____

WORK PHONE _____ BIRTHDATE _____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME _____

ADDRESS _____

CITY, STATE _____ PHONE _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____

If you have double dental insurance coverage, complete this for the second coverage.

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of _____'s dental needs.
(Name of Patient)

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I 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 can ask for a complete recital of any possible complication.

4. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fee's are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fee's incurred. I further understand that a late charge may be added to any overdue balance.

_____ _____

Patient Signature (parent of child) Date DENTIST'S signature

PATIENT NAME	MEDICAL HISTORY
PATIENT ACCOUNT NO.	MEDICAL ALERT

1. Have you been under the care of a medical doctor during the past two years? ..... Yes No
   If yes, for what? _____
   Physician's Name _____ Phone _____
   Address _____ City _____ State _____ Zip _____
2. Have you taken any medications or drugs during the past two years? ..... Yes No
3. Are you taking any medication, drugs or pills now? ..... Yes No
   If yes, please list name and dosage _____
4. Are you aware of having an allergic **(or adverse reaction)** to any medication or substance? ..... Yes No
   If yes, please list: _____
5. Have you been a patient in the hospital during the past five years? ..... Yes No
6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (infectious) B (serum)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Diease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact Lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

7. Do you use more than two pillows to sleep? ..... Yes No
8. Have you lost or gained more than 10 pounds in the past year? ..... Yes No
9. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No
   If yes, please list: .....
10. **Women.** Are you: **Pregnant?** Yes,____Months No **Nursing?** Yes No **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 to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature ..... Date .....

History Review

Doctor Signature ..... Date .....

PATIENT NAME	DENTAL HISTORY
PATIENT ACCOUNT NO.	MEDICAL ALERT

What is the reason for your visit today? _____

_____

Date of Last Dental Visit _____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays** _____

What was done at your last dental visit? _____

_____

Previous Dentist's Name _____

Address _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

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
Sweets?	Yes	No
Biting or Chewing	Yes	No
Have you noticed any odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease or tooth loss?	Yes	No
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? _____

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regulary?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breath while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause _____

_____

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No
If so, what is your biggest concern?	Yes	No

_____

Have you ever had an upsetting dental experience? Yes No

If so, please describe, including cause _____

_____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe: _____

_____

_____

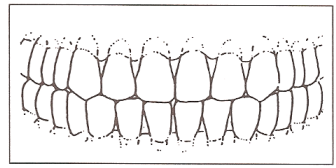
(Please complete other side)

A Simple Quiz To Help You Obtain the Smile You've Always Wanted.

Smile Evaluation

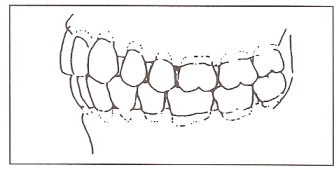
Hold a full face mirror 12" - 14" from your face. Smile to show your teeth; take the time to observe your teeth carefully. Then answer the following questions. (It is helpful to have a friend ask you the questions.)

1 Do you like the appearance of your teeth, your smile? ❒ Yes ❒ No
If not, explain _____



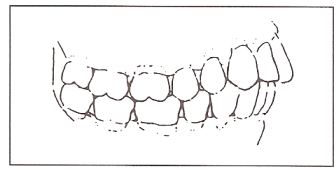
2 Are your teeth all in alignment (straight)? ❒ Yes ❒ No
If not, explain _____

3 Do you have spaces that you don't like? ❒ Yes ❒ No
If not, explain _____

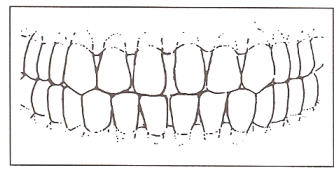


4 Do you like the color of your teeth? ❒ Yes ❒ No
If not, explain _____

5 Do you like the shape of your teeth? ❒ Yes ❒ No
If not, explain _____

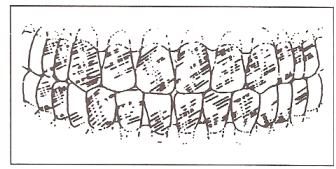


6 Are your teeth ...
chipped? _____ protruding? _____ hidden? _____



7 Do you like the way your teeth come together? ❒ Yes ❒ No
If not, explain _____

8 Are there old fillings or dental work that you don't like looking at? ❒ Yes ❒ No
If not, explain _____



9 What would you like to change the most in the appearance of your teeth?

10 How would you like your teeth to look?