

### PATIENT REGISTRATION 1

If this appointment is <u>for you</u> start here **1** 

If this

1

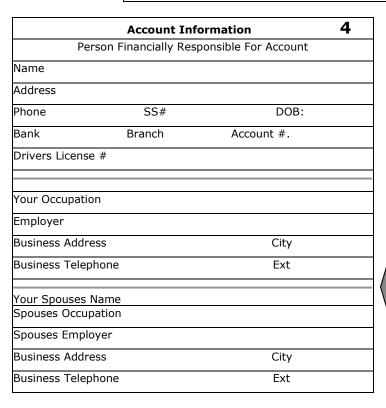
start here

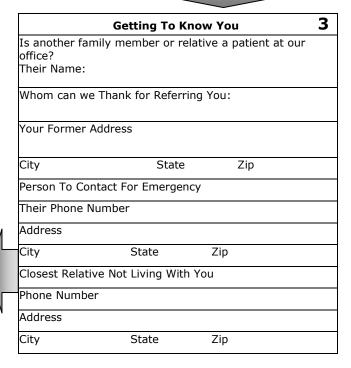
appointment is for your child,

## Please Complete The Following Confidential Information:

1 Date Name Prefer to be called Address City State Zip Home Phone Cell Phone E-mail Address Birth date Soc. Sec. # Married Single Divorced Widowed Date Name Prefer to be called Guardian at appointment Address City State Zip Home Phone Birth date Soc. Sec # School

2 **Dental Benefits Primary Carrier** Employee Benefit Company Address Phone Group # Employee ID # Emp Social Security # DOB: Date Employed: **Secondary Carrier** Employee Benefit Company Address Phone Group # Employee ID# Emp Social Security # DOB: Date Employed





09/08/2009



# **CONSENT FOR TREATMENT 2**

1.	I hereby authorize doctor or designated photographs and any other diagnostic a make a thorough diagnosis of (name of needs.	ids deemed appropriate by doctor to
2.	Upon such diagnosis, I authorize doctor mutually agreed upon by me and to en provide proper care.	
3.	I agree to allow the use of diagnostic adju professionals to assist in my care and with and for educational purposes and limited p	insurance companies to allow benefits
4.	I fully understand that I agree to the use of medications as necessary and previously a using anesthetic agents embodies certain recital of possible complications.	agreed to by me. I fully understand that
5.	We are pleased to reserve time uniquely person's appointment at your reserved time commitment of time between you and ou keep your scheduled appointment, we as eight business hours notice to us so we metreatment. If you fail to attend at your reservace available basis, rather than by reservacept a non refundable prepayment for your reservace.	e. Since a scheduled appointment is a r practice, if you find that you cannot k you to provide a minimum of fortyay schedule another patient in need of erved time, we may see you on a daily rvation. As an alternative we may also
Pa	atient Name:	
Pa	atient Signature:	Date:
R	esponsible Party Name:	Date:
R	elationship to Patient:	
	HIPPA Acknowledgement of Receipt o	-
I. (Na		
office	me): 's Notice of Privacy Practices.	,,
Signa	ature: Da	ate:



### **DENTAL HISTORY 3**

Patient Name

**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:

Date of Last Dental Visit Last I What was done at your last dental visit?	Dental C	leanin	g Last Full Mouth X-Rays	
Previous Dentist's Name				
Address			StateZip	
「elephone				
How often do you have dental examinations? How often do you brush your teeth? What other dental aids do you use? (Electric Brush,	toothnic	How	often do you floss?	
Do you have any dental problems now?	Yes		No	
r yes, please describe:				
Are any of your teeth sensitive to:	V	NI-		
Hot or cold?	Yes	No	Have you ever had.	
Sweets?	Yes	No	Have you ever had:	Vaa
Biting or Chewing	Yes	No	Orthodontic treatment?	Yes
Have you noticed any mouth odors or bad tastes?	Yes	No	Oral Surgery?	Yes
o you frequently get Cold sores, Fever blisters or any	V	NI-	Periodontal treatment?	Yes
ther oral lesions?	Yes	No	Your teeth ground or the bite adjusted?	Yes
	V	NI-	A bite plate or mouth guard?	Yes
Oo your gums bleed or hurt?	Yes	No	A serious injury to the mouth or head?	Yes
Have your parents experienced gum disease or tooth lo Have you noticed any loose teeth or change in your bit Does food tend to become caught in between your teel	e? Yes	No No No	If so, please describe including cause	<del></del>
f yes, where?	_		Have very assession and	
Do you:			Have you experienced:	
oo you.			Clicking or popping of the jaw?	Yes
Clench or grind your teeth while awake or asleep?	Yes	No	Pain? (joint, ear, side of face)	Yes
Bite your lips or cheeks regularly?	Yes	No	Difficulty in opening or closing the mouth?	Yes
Hold foreign objects with your teeth?	Yes	No	Difficulty in chewing on either side of the mouth?	Yes
pencils, pipe, pins, nails, fingernails)	Yes	No	Headaches, neckaches or shoulder aches?	Yes
Nouth breath while awake or asleep?	Yes	No	Sore muscles (neck, shoulders)?	Yes
lave tired jaws, especially in the morning?	Yes	No	Sore muscles (neck, shoulders):	103
Smoke/chew tobacco?	Yes	No	Are you satisfied with your teeth's appearance?	Yes
f yes, how many packs a day? for yea		INO	Would you like to keep all of your teeth all of your life?	
			, , , , , , , , , , , , , , , , , , , ,	
Do you feel nervous about having dental treatment? f so what is your biggest concern?	Yes	No		
Have you ever had an upsetting dental experience? if yes, please describe	Yes	No		
places honorthy chara with us your expectations regular	arding v	our tres	stment, the doctor, the staff and the office:	

(Please complete other side)

Ver. 09/08/2009



Doctor Signature\_

#### **MEDICAL HISTORY 4**

Patient Name 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 Zip State 2. Have you taken any medication during the past two years including appetite suppressants - fen-phen, Including Tagamet(Cimetidine)?...Antacids?... If yes how often?.... If yes, please list name and dosage\_ To Local Anesthetics?..... To Penicillin or Antibiotics... Aspirin.... Codeine, Valium or Sedatives.... 7. 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 Diabetes.....Yes No Hepatitis B (serum).....Yes No Chest Pain.....Yes No Thyroid Problems......Yes No Venereal Disease.....Yes No A.I.D.S.....Yes No Congenital Heart Disease.....Yes No Glaucoma.....Yes No Heart Murmur.....Yes No Contact Lenses.....Yes No H.I.V. Positive.....Yes No High Blood Pressure.....Yes No Cold Sores/Fever Blisters.....Yes No Emphysema.....Yes No Blood Transfusion......Yes No Mitral Valve Prolapse.....Yes No Chronic Cough......Yes No Artificial Heart Valve.....Yes No Tuberculosis.....Yes No Hemophilia.....Yes No Sickle Cell Disease.....Yes No Heart Pacemaker.....Yes No Asthma.....Yes No RheumaticFever.....Yes..No Bruise Easily.....Yes No Arthritis/Rheumatism.....Yes No Liver Disease.....Yes No Latex Sensitivity......Yes No Cortisone Medicine.....Yes No Allergies or Hives......Yes No Yellow Jaundice.....Yes No Swollen Ankles.....Yes No Sinus Trouble.....Yes No Neurological Disorders.....Yes No Epilepsy or Seizures.....Yes No Stroke.....Yes .No Sore or Enlarged Lymph Nodes Yes.No Fainting.or.Dizzy.Spells.....Yes...No Diet(Special/Restricted)......Yes...No Cancer/Tumors.....Yes..No ArtificialJoints(hip,knee,etc.)....Yes....No Radiation Therapy/Biopsies.....Yes No Nervous/Anxious.....Yes..No Psychiatric/PsychologicalCare....Yes No Kidney Trouble.....Yes .No Chemotherapy.....Yes No Cosmetic Augmentation ......Yes..No Ulcers......Yes .No Hepatitis A (infectious) ......Yes..No 9. Have you lost or gained more than 10 pounds in the past year?......Yes No \_\_ Current Weight 10. Do you have or have you had any disease, condition, or problem not listed?.....Yes No If yes, please list:\_ 11. Women. Are you: Pregnant? Yes\_\_\_ Months No Nursing? Yes No Taking birth control pills?.....Yes No 12. **Men**: Are you Taking: Viagara, Cialis or Levitra Yes. No (May change blood pressure when mixed with other meds. 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. (Please complete other side) Patient/Guardian Signature Date **History Review** Ver.09/08/09 **Findings** М Μ S **Dental Management Considerations** 

Date