PATIENT REGISTRATION AND HEALTH RECORD

In order to help us render the proper dental services to you, would you please be kind enough to answer the following questions. Please note the space for remarks for any answers that require clarification or any other information you think we should have. Thank you for your cooperation.

PATIENT: Dr. Mr. Mrs. Ms. Miss

Last Name	First	M.I.	Preferred
Res. Tel. ( )	Bus. Tel. ( )	Date Of Birth	
Social Security Number	Driver's License Number		
Home Address	City	State	Zip Code
Employer	Occupation / School		
Employer's Address	City	State	Zip Code

SPOUSE or PARENT: Person Responsible For Account

Last Name	First	M.I.	Date Of Birth
Social Security Number	Driver's License Number		
Employer	Occupation	Bus. Tel. ( )	
Employer's Address	City	State	Zip Code

Person to notify in case of emergency:

Name	Relationship	Res. Tel. ( )
Address	City / Zip code	Bus. Tel. ( )

INSURANCE:

Primary Carrier (Self)	Secondary Carrier (Spouse)
Name of Employee	Name of Employee
Social Security Number	Social Security Number
Date of Birth	Date of Birth
Group Number	Group Number

DENTAL HISTORY:

Previous Dentist	Telephone ( )	
Address	City	State / Zip Code

Date of last complete series of X-rays? _____

Purpose for visit? _____

How do you feel about the appearance of your teeth? _____

Are you having pain at this time? ( ) Yes ( ) No

Have you noticed any loosening of your teeth? ( ) Yes ( ) No

Does food tend to become caught between your teeth? ( ) Yes ( ) No

Do you suffer from pain and/or swelling of your gums? ( ) Yes ( ) No

Do your gums sometimes bleed when you brush or floss? ( ) Yes ( ) No

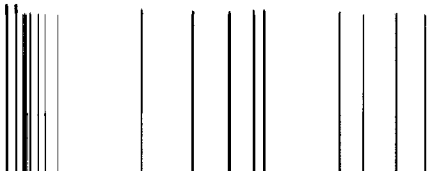
Have you ever had an upsetting experience in the dental office? ( ) Yes ( ) No

Are your teeth sensitive to: Hot, Cold, Sweets and/or Pressure? ( ) Yes ( ) No

Do you clench or grind your teeth during sleep or daytime? ( ) Yes ( ) No

Do your jaws ever feel tired? ( ) Yes ( ) No

Do you have frequent headaches, earaches or neck pain? ( ) Yes ( ) No



Medical Health

1) Are you taking any medication now? ( ) Yes ( ) No, If yes please list name & usage.

_____

_____

_____

2) Are you allergic and/or sensitive to: ( ) Penicillin ( ) Codeine ( ) Local injected anesthetics ( ) None
( ) Other medications, Please list: _____

3) Have you ever had an unfavorable reaction to local anesthetics? ( ) Yes ( ) No

4) Have you ever been treated (other than diagnostic) with X rays (radiation treatment) ? ( ) Yes ( ) No

5) Do you have a surgical implant or pacemaker? ( ) Yes ( ) No

6) General health (please check): ( ) Excellent ( ) Good ( ) Fair ( ) Poor

7) Last complete physical? _____

8) Are you under the care of a physician now? ( ) Yes ( ) No, If yes, for what reason? _____

9) Have you had any serious illiness or operation? ( ) Yes ( ) No, If yes, for what reason?

_____

10) Have you ever had a contagious illiness?
( ) Aids/HIV ( ) Hepatitis ( ) Tuberculosis ( ) Herpes ( ) Sexually transmitted disease ( ) None ( ) Other

11) Have you ever had or been treated for:

( )Yes ( )No Heart ailments and/or murmur
( )Yes ( )No Rheumatic fever/rheumatic heart disease
( )Yes ( )No Prosthetic valve, mitral proplapse, etc.
( )Yes ( )No Prosthetic hip/joint
( )Yes ( )No Chemotherapy
( )Yes ( )No Heart Attack
( )Yes ( )No High blood pressure
( )Yes ( )No Stroke
( )Yes ( )No Cancer

( )Yes ( )No Kidney disease or malfunction
( )Yes ( )No Thyroid disease or malfunction
( )Yes ( )No Diabetes
( )Yes ( )No Asthma, Hay fever or Sinus trouble
( )Yes ( )No Glaucoma
( )Yes ( )No Rheumatism or Arthritis
( )Yes ( )No Epilepsy, Fainting Spells or Seizures
( )Yes ( )No Nervous disorders
( )Yes ( )No Difficulty in breathing

12) Are you subject to prolonged bleeding? ( )Yes ( )No

13) Women: Are you pregnant? ( )Yes ( )No, Due date: _____

14) Do you have any disease, condition, or problems not listed above that you think we should know about?
If so, please explain: _____

_____

Referred by: _____

Name/Address of physician

_____

_____

_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____

Signature of Patient Date:

Medical History update (subsequent use only):

Date: Comments: Signature:

_____

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