REGISTRATION AND HEALTH HISTORY

Name ______________________ Single______ Married______ Divorced ______ Separated ______ Widowed ______

Social Security Number______________ Birthdate ____________ Home Phone ____________ Business Phone ______________

Residence Address ______________________________ City ______________ State ______ Zip __________

Employed By ______________________________ City ______________ State ______ Zip __________

Present Position ______________ How Long Held ________ Your Driver License No. ______________ State ________

Spouse Name ______________________

Spouse's Social Security Number ______________ Spouse Birthday ____________ Business Phone ______________

Spouse Employed By ______________________ City ______________ State ____________ Zip__________

Present Position ______________ How Long Held ________ Spouse Driver License No. ______________ State ________

Referred By ______________________ Address ______________________________

Who will pay for this account?______________ Credit Card Name ____________ No. & Expiration Date ______________

Name of your dental insurance company ______________________________________

Union Local ______________________ Group No. ______________ Policy No. ______________

Name of your spouse's dental insurance company ______________________________________

Union Local ______________________ Group No. ______________ Policy No. ______________

Dental History

Do you have a specific dental problem? Describe______________________________ Yes No

Do you have dental examinations on a routine basis? Last visit______________________________ Yes No

Do you think you have active decay or gum disease? ______________________________ Yes No

Do you brush and floss on a routine basis? ______________________________ Yes No

Do your gums ever bleed? Discuss ______________________________ Yes No

Does food catch between your teeth? Any loose teeth? ______________________________ Yes No

Do you want to keep your remaining teeth? ______________________________ Yes No

Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? ______________ Yes No

Have your past experiences in a dental office always been positive? ______________________________ Yes No

Do you smoke or chew? Any sores or growths in your mouth? Discuss ______________________________ Yes No

Name of previous dentist (optional): ______________________________ Yes No

Date of last full mouth x-rays (16 small films or panoramic): ______________________________ Yes No

Have you or any member of your family been a patient in our office before? ______________________________ Yes No

If so, who? ______________________

(over)

Medical History

Are you under a physician's care now? Why? ______________________ Phone # ______________ Yes No

Have you ever been hospitalized or had a major operation? Discuss ______________________ Yes No

Have you ever had a serious injury to your head or neck? Discuss ______________________ Yes No

Are you taking any medications, pills or drugs? What? ______________________ Yes No

Are you on a special diet? Discuss ______________________ Yes No

Are you allergic to any medications or substances? Please check box below Yes No

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex Rubber ❑ Other ______________

Women (Please check): ❑ Pregnant/trying to get pregnant ❑ Nursing ❑ Taking oral contraceptives Discuss Yes No

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Do you now have or have you ever had any of the following? Please check only if yes.

Yes No	Yes No	Yes No	Yes No	Yes No
❑ ❑ Heart Trouble/Disease	❑ ❑ Bruise Easily	❑ ❑ Emphysema	❑ ❑ Yellow Jaundice	❑ ❑ Cold Sores
❑ ❑ Heart Murmur	❑ ❑ Anemia	❑ ❑ Tuberculosis	❑ ❑ Kidney Problems	❑ ❑ Fever Blisters
❑ ❑ Irregular Heart Beat	❑ ❑ Excessive Bleeding	❑ ❑ Cancer	❑ ❑ Renal Dialysis	❑ ❑ Herpes
❑ ❑ Angina/Chest Pain	❑ ❑ Sickle Cell Disease	❑ ❑ X-Ray Treatments (Radiation)	❑ ❑ Thyroid Disease	❑ ❑ Stroke
❑ ❑ Heart Attack/Failure	❑ ❑ Hemophillia (Bleeding Problem)	❑ ❑ Chemotherapy	❑ ❑ Parathyroid Disease	❑ ❑ Convulsions
❑ ❑ Congenital Heart Disorder	❑ ❑ Leukemia	❑ ❑ Stomach/Intestinal Disease	❑ ❑ Arthritis/Gout	❑ ❑ Epilepsy or Seizures
❑ ❑ Mitral Valve Prolapse	❑ ❑ Recent Blood Transfusion	❑ ❑ Ulcers	❑ ❑ Rheumatism	❑ ❑ Fainting or Dizziness
❑ ❑ Scarlet Fever	❑ ❑ Swelling of Limbs	❑ ❑ Recent Weight Loss	❑ ❑ Pain in Jaw Joints	❑ ❑ Glaucoma
❑ ❑ Rheumatic Fever	❑ ❑ Lung Disease	❑ ❑ Frequent Diarrhea	❑ ❑ Cortisone Medicine	❑ ❑ Tumors or Growths
❑ ❑ Artificial Heart Valve	❑ ❑ Breathing Problem	❑ ❑ Diabetes	❑ ❑ Artificial Joint	❑ ❑ Nervousness
❑ ❑ Heart Pace Maker	❑ ❑ Shortness of Breath	❑ ❑ Excessive Thirst	❑ ❑ Venereal Disease	❑ ❑ Psychiatric Care
❑ ❑ Heart Surgery	❑ ❑ Frequent Cough	❑ ❑ Hypoglycemia	❑ ❑ AIDS	❑ ❑ Alzheimer's Disease
❑ ❑ High Blood Pressure	❑ ❑ Hay Fever	❑ ❑ Liver Disease	❑ ❑ HIV Positive	❑ ❑ Allergies (Medicines)
❑ ❑ Low Blood Pressure	❑ ❑ Sinus Trouble	❑ ❑ Hepatitis A (Infectious)	❑ ❑ Genital Herpes	❑ ❑ Allergies (Pollen/Dust)
❑ ❑ Blood Disease	❑ ❑ Asthma	❑ ❑ Hepatitis B or C	❑ ❑ Drug Addiction	❑ ❑ Hives or Rash

Have you ever had any other serious illness not checked above? Discuss ______________________ Yes No

Do you wish to talk to the dentist privately about any problem? ______________________ Yes No

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PERSON TO CONTACT IN CASE OF EMERGENCY

Outside of Immediate Family/Household

Name ______________________

Address ______________________

City/State/Zip ______________________

Telephone # ______________________

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third payers and/or other health professionals.

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❑ Adult Patient ❑ Father (Or Husband) ❑ Mother (Or Wife) ❑ Guardian

____

Date State Driver's License #

PERSON TO CONTACT IN CASE OF EMERGENCY

Please Check One

❑ Patient ❑ Father (or Husband)

❑ Guardian ❑ Mother (Or Wife)

METHOD OF PAYMENT

Responsible party currently has an account with this office

❑ YES ❑ NO

❑ Payment in full at each appointment (cash or personal check)

❑ Payment in full at each appointment (❑ VISA ❑ MC)

Card # ______________ Exp. Date ______________

❑ I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE

If do not pay the entire new balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $3.00 for a balance under $200.00) which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.