PATIENT REGISTRATION AND HEALTH HISTORY

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DATE	1		
NAME			
SPOUSE			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO. ( )			
CELL PHONE NO. ( )			
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
EMAIL ADDRESS			
SOCIAL SECURITY NO.			
DATE			
NAME			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO. ( )			
BIRTHDATE	AGE	MALE	FEMALE
EMAIL ADDRESS			

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO.

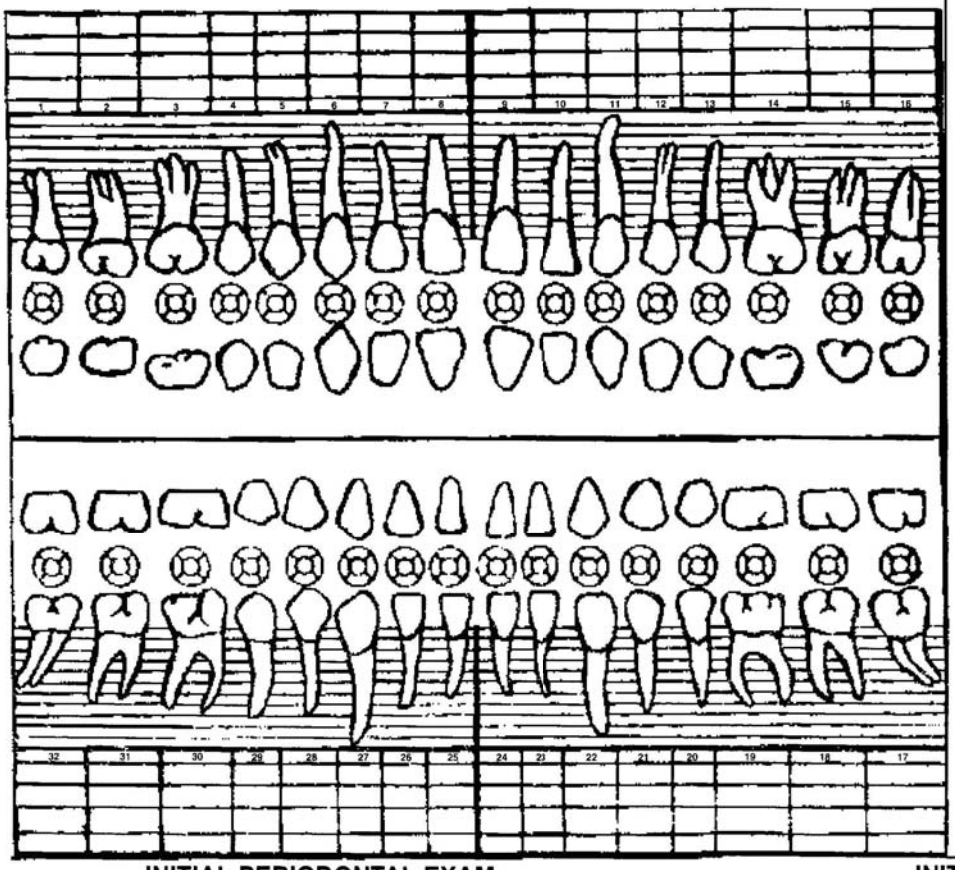
DENTAL INSURANCE	2
PRIMARY CARRIER	
INSURANCE COMPANY	
EMPLOYEE	
DATE OF BIRTH	
GROUP NO.	
UNION OR LOCAL NO.	
DATE EMPLOYED	
EMP. SOCIAL SECURITY NO.	
EFFECTIVE DATE OF INS.	
DEDUCTIBLE:____ YES ____ NO	
$ AMOUNT	
IF YES: INDIVIDUAL	FAMILY
PERCENTAGE: %	
SECONDARY CARRIER	
INSURANCE COMPANY	
EMPLOYEE	
DATE OF BIRTH	
GROUP NO.	
UNION OR LOCAL NO.	
DATE EMPLOYED	
EMP. SOCIAL SECURITY NO.	
EFFECTIVE DATE OF INS.	
DEDUCTIBLE:____ YES ____ NO	
$ AMOUNT	
IF YES: INDIVIDUAL	FAMILY
PERCENTAGE: %	

ACCOUNT INFORMATION	4
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT	
NAME	
DRIVERS LICENSE NO.	RELATIONSHIP TO PATIENT
YOU:	
NAME	
OCCUPATION	
EMPLOYER	
BUSINESS ADDRESS	CITY
BUSINESS TELEPHONE ( )	EXT
YOUR SPOUSE:	
NAME	
OCCUPATION	
EMPLOYER	
BUSINESS ADDRESS	CITY
BUSINESS TELEPHONE ( )	EXT

GETTING TO KNOW YOU	3
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?	
THEIR NAME:	
REFERRED TO US BY	
EMERGENCY INFORMATION	
NAME OF CLOSEST RELATIVE NOT LIVING WITH YOU	
PHONE NUMBER ( )	
ADDRESS	
CITY	STATE ZIP

PLEASE SIGN CONSENT INSIDE

PERIDONTAL EXAM: DATE:_____



MEDICAL ALERT

1. Existing Illnesses:_____
2. Current Drugs Used:_____
3. Allergies:_____
4. History of Bleeding:_____
5. Blood Pressure:_____
6. Problems not listed?_____

INITIAL PERIODONTAL EXAM:

GINGIVAL INFLAMATION:	❒ Slight	❒ Moderate	❒ Severe
SOFT PLAQUE BUILDUP:	❒ Slight	❒ Moderate	❒ Heavy
HAND CALC. BUILDUP:	❒ Light	❒ Moderate	❒ Heavy
STAINS:	❒ Light	❒ Moderate	❒ Heavy
HOME CARE EFFECTIVENESS:	❒ Good	❒ Fair	❒ Poor
PERIDONTAL CONDITION:	❒ Good	❒ Fair	❒ Poor
PERIDONTAL DIAGNOSIS:	❒ Normal	❒ Gingivitis	
PERIODONTITIS:	❒ Early	❒ Moderate	❒ Advanced

MUCOGINGIVAL DEFECTS #s: _____

CLINICAL DATA:

OCCLUSION: ❒ Class I ❒ Class II ❒ Class III ❒ Crossbite:_____

T.M.J. EXAM: ❒ Normal ❒ Popping ❒ Deviation ❒ Tooth Wear ❒ Pain

INITIAL SOFT TISSUE EXAM:

❒ Lips ❒ Floor of Mouth ❒ Palate ❒ Tongue ❒ Neck & Nodes

PATIENT'S TREATMENT DECISIONS:

❒ DOCUMENTATION OF DENTAL RECORD COMPLETED

❒ PATIENT INFORMED OF TX. RECOMMENDATIONS AND CONSENTS TO TX. (ALTERNATIVES DISCUSSED.)

❒ PATIENT WANTS NO TX. OR PARTIAL TX. INFORMED OF CONSEQUENCES AND RISKS INVOLVED.

INITIAL X-RAY FINDINGS:

X-RAYS TAKEN: ❒ FM-PAS ❒ BWX ❒ PANO. ❒ OTHER _____

❒ NO BONE LOSS
❒ SLIGHT BONE LOSS (04600)
❒ MODERATE BONE LOSS (04700)
❒ MAJOR BONE LOSS (04800)
❒ BEGINNING FURCATION (04700)
❒ ADVANCED FURCATION (04800)
❒ OTHER: _____

QUADRANTS

UR	UL	LR	LL

REFERRALS:

PERIO:_____ ORTHO:_____ ENDO:_____

ORAL SURG:_____ M.D._____ OTHER _____

LAB:_____ N_2O:_____

MODELS_____ MOST N.B._____

PHOTOS: 1._____ INSUR._____

2._____ BP + DATE:_____

EXISTING PROSTHESIS:

MAX._____ DATE PLACED:_____ CONDITION:_____

MAND._____ DATE PLACED:_____ CONDITION:_____

CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, sturdy models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. 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 fees 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 fees incurred. I further understand that a late charge will be added to any overdue balance.

PATIENT SIGNATURE (Parent of Child):_____ DATE:_____

DENTIST SIGNATURE:_____