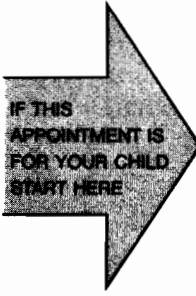


PATIENT REGISTRATION AND HEALTH HISTORY

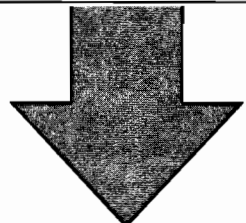
PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION



DATE				1
NAME				
SPOUSE				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.				
BIRTHDATE	AGE	MALE	FEMALE	
MARRIED	SINGLE	DIVORCED	WIDOWED	
SOCIAL SECURITY NO.				
DATE				
NAME				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.				
BIRTHDATE	AGE	MALE	FEMALE	
SCHOOL		GRADE		
SOCIAL SECURITY NO.				
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		
GROUP NO.		
EMPLOYEE		
DATE OF BIRTH	DATE EMPLOYED	
UNION OR LOCAL NO.		
EMPLOYEE NO.		
EMPLOYEE SOCIAL SECURITY NO.		
SECONDARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYEE		
DATE OF BIRTH	DATE EMPLOYED	
UNION OR LOCAL NO.		
EMPLOYEE NO.		
EMPLOYEE SOCIAL SECURITY NO.		



ACCOUNT INFORMATION		4
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT		
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
YOU		
NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS	CITY	
BUSINESS PHONE NO.	EXT.	
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS	CITY	
BUSINESS PHONE NO.	EXT.	



GETTING TO KNOW YOU		3
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
NAME:	RELATIONSHIP:	
REFERRED TO US BY		
YOUR FORMER ADDRESS		
CITY	STATE	ZIP
PERSON TO CONTACT FOR EMERGENCY		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP

1. Are you having pain or discomfort at this time? YES NO
2. Have you been a patient in the hospital during the past two years? YES NO
3. Have you been under the care of a medical doctor during the past two years? YES NO

Physician's Name _____ Phone No. _____
 Address _____

4. Have you taken any medication or drugs during the past two years? YES NO
5. Are you now taking any medication, drugs or pills? YES NO
 If yes, please list: _____
6. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? YES NO
 If yes, please list: _____

7. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.
- | | | |
|---------------------------------------|--|--|
| Heart Failure YES NO | Artificial Joints (hip, knee, etc.) ... YES NO | Hepatitis B (serum) YES NO |
| Heart Disease or Attack YES NO | Kidney Trouble YES NO | Venereal Disease YES NO |
| Angina Pectoris YES NO | Ulcers YES NO | A.I.D.S. YES NO |
| Congenital Heart Disease YES NO | Diabetes YES NO | H.I.V. Positive YES NO |
| Heart Murmur YES NO | Thyroid Problems YES NO | Cold Sores/Fever Blisters YES NO |
| High Blood Pressure YES NO | Glaucoma YES NO | Blood Transfusion YES NO |
| Arteriosclerosis YES NO | Cosmetic Surgery YES NO | Hemophilia YES NO |
| Mitral Valve Prolapse YES NO | Emphysema YES NO | Anemia YES NO |
| Artificial Heart Valve YES NO | Chronic Cough YES NO | Sickle Cell Disease YES NO |
| Heart Pacemaker YES NO | Tuberculosis YES NO | Bruise Easily YES NO |
| Heart Surgery YES NO | Asthma YES NO | Liver Disease YES NO |
| Rheumatic Fever YES NO | Hay Fever YES NO | Yellow Jaundice YES NO |
| Arthritis YES NO | Allergies or Hives YES NO | Epilepsy or Seizures YES NO |
| Rheumatism YES NO | Sinus Trouble YES NO | Fainting or Dizzy Spells YES NO |
| Cortisone Medicine YES NO | Radiation Therapy YES NO | Nervousness YES NO |
| Drug Addiction YES NO | Chemotherapy YES NO | Psychiatric Treatment YES NO |
| Stroke YES NO | Hepatitis A (infectious) YES NO | Developmentally Disabled YES NO |

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? YES NO
9. Do your ankles swell during the day? YES NO
10. Do you use more than two pillows to sleep? YES NO
11. Have you lost or gained more than 10 pounds in the past year? YES NO
12. Do you ever wake up from sleep and feel short of breath? YES NO
13. Are you on a special diet? YES NO
14. Has your medical doctor ever said you have a cancer or tumor? YES NO
15. Do you have or have you had any disease, condition, or problem not listed? YES NO
 If yes, please list: _____

FOR WOMEN ONLY:

Are you pregnant? Yes, what month? _____ No Are you nursing? Yes No Are you 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 truthfully and to the best of my knowledge.

Patient Signature _____ Date _____

CONSENT:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. Lastly, I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____