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.

			<u> </u>		-	
Date of Last Dental VisitLast Den	tal Cle	eaning	Last Full Mouth X-rays			
CHANGE STANDED STANDER						
Address			State Zip_			
Telephone						
How often do you have dental examinations?						
			How often do you floss?			
Do you have any dental problems now? Yes	No					
If yes, please describe:						
Are any of your teeth senstive to:			Have you ever had:			
Hot or cold?	Yes	No	Orthodontic treatment?	Yes	No	
Sweets?	Yes	No	Oral Surgery?	Yes	No	
Biting or Chewing?	Yes	No	Periodontal treatment?	Yes	No	
Have you noticed any mouth odors or bad tastes?	Yes	No	Your teeth ground or the bite adjusted?	Yes	No	
Do you frequently get cold sores, blisters or		7000	A bite plate or mouth guard?	Yes	No	
any other oral lesions?	Yes	No	A serious injury to the mouth or head?	Yes	No	
NET 121 121 2 1021	22		If so, please describe, including cause			
Do your gums bleed or hurt?	Yes	No				
Have your parents experienced gum disease	V		Have you assessed			
or tooth loss?	Yes	No	Have you experienced:	Voc	Ma	
Have you noticed any loose teeth or change	Voo	Ma	Clicking or popping of the jaw? Pain? (joint, ear, side of face)	Yes Yes	No No	
in your bite?	Yes	No	Difficulty in opening or closing the mouth?	Yes	No	
Does food tend to become caught in between your teeth?	Yes	No	Difficulty in chewing on either side of the mouth?	Yes	No	
If yes, where?	162	NO	Headaches, neckaches or shoulder aches?	Yes	No	
ii yes, wilete:			Sore muscles (neck, shoulders)?	Yes	No	
Do you:			outs massiss (mostly strongers).			
Clench or grind your teeth while awake or asleep?	Yes	No	Are you satisfied with your teeth's appearance?	Yes	No	
Bite your lips or cheeks regularly?	Yes	No	Would you like to keep all of your teeth all of your life?		No	
Hold foreign objects with your teeth?						
(pencils, pipe, pins, nails, fingernails)	Yes	No	Do you feel nervous about having dental treatment?	Yes	No	
Mouth breathe while awake or asleep?	Yes	No	If so, what is your biggest concern?			
Have tired jaws, especially in the morning?	Yes	No				
Snore or have any other sleeping disorders?	Yes	No	Have you ever had an upsetting dental experience?	Yes	No	
Smoke/chew tobacco or use other tobacco products?	Yes	No	If yes, please describe			
a those anything also should be in a deutal transfer	må åL	n t war-	would like us to know?	Yes	No	
s there anything else about having dental treatme		-	would like us to know?		IVC	

Chest Pain. Yes No Diabetes. Yes No Venereal Disease. Congenital Heart Disease. Yes No Thyroid Problems. Yes No A.I.D.S. Heart Murmur Yes No Glaucoma Yes No H.I.V. Positive. High Blood Pressure Yes No Contact lenses. Yes No Cold Sores/Fever Blis Mitral Valve Prolapse. Yes No Emphysema Yes No Blood Transfusion. Artificial Heart Valve. Yes No Chronic Cough. Yes No Hemophilia. Heart Pacemaker. Yes No Tuberculosis. Yes No Sickle Cell Disease. Rheumatic Fever. Yes No Asthma. Yes No Bruise Easily. Arthritis/Rheumatism. Yes No Hay Fever. Yes No Liver Disease. Cortisone Medicine. Yes No Allergies or Hives. Yes No Neurological Disorder Stroke. Yes No Sinus Trouble. Yes No Fainting or Dizzy Spe Artificial Joints (hip, knee, etc.) Yes No Tumors. Yes No Psychiatric/Psycholog. 8. Do you use more than two pillows to sleep? 9. Have you lost or gained more than 10 pounds in the past year? If yes, please list:	Zip Yes edicines? Yes dimen (fenfluramine); Yes	No
If yes, for what? Physician's Name	Zip Yes edicines? Yes dimen (fenfluramine); Yes	No
Physician's Name	Zip Yes edicines? Yes edicines? Yes	
Address	Zip Yes edicines? Yes Yes dimen (fenfluramine); Yes	
 Have you taking any medication or drugs during the past two years? Are you taking any medication or drugs currently, including regular doses of aspirin or over-the-counter herbal medicines If yes, please list name and dosage Have you ever taken any prescription drugs for weight loss, including Fen-Phen (fenfluramine-phentermine); Pondimen (ff and Redux (dexfenfluramine)? If yes to the above, did you have a medical exam for heart issues? Are you aware of having an allergic (or adverse) reaction to any medication or substance? If yes, please list: Have you been a patient in the hospital during the past five years? 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 Ulcers Yes No Venereal Disease. Congenital Heart Disease. Yes No Diabetes Yes No Venereal Disease. Congenital Heart Disease. Yes No Gilaucoma. Yes No H.I.V. Positive. High Blood Pressure. Yes No Golaucoma. Yes No Contact lenses. Yes No Cold Sores/Fever Blis Mitral Valve Prolapse. Yes No Emphysema. Yes No Blood Transfusion. Artificial Heart Valve. Yes No Chronic Cough. Yes No Hemophilia. Heart Pacemaker. Yes No Tuberculosis. Yes No Bruise Easily. Arthritis/Rheumatism. Yes No Altergies or Hives. Yes No Revisease. Cortisone Medicine. Yes No Altergies or Hives. Yes No Periological Disorder Stroke. Yes No Revisitivity. Yes No Periological Disorder Stroke. Yes No Revisitivity. Yes No Periological Disorder Stroke. Yes No Revisitivity Yes No Periolog	dimen (fenfluramine);	
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11. Women: Are you pregnant or think you may be pregnant? Yes, who would not include the nursing?	Yes d efficient manner. I ha you have my permissi	
12. Women: Do you use birth control medications?	d efficient manner. I ha you have my permissi	No
	you have my permissi	
I understand the above information is necessary to provide me with dental care in a safe and efficient answered all questions to the best of my knowledge. Should further information be needed, you hat the respective health care provider or agency, who may release such information to you. I will notify changes in my health or medication.		on to a
Patient/Guardian Signature Date	Date	
History Review		_55

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

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FORM 001 (12/96)

PATIENT REGISTRATION

	DATE			*	1		DENTA	AL INSURANCE 2	
Α.	LAST NAME	F	IRST	M.I. PRIMARY CARRIER			ARY CARRIER		
	PREFERS TO B	E CALLED BY					INSURANCE COMPANY		
IF THIS	ADDRESS						GROUP NO.		
APPOINTMENT	CITY		STATE	ZIP		,	EMPLOYER NAME	-	
IS FOR YOU START HERE	HOME PHONE	NO.			-		INSURED'S NAME		
	BIRTHDATE	AGE	MALE	FEMALE		•	DATE OF BIRTH	RELATIONSHIP TO PATIENT	
	MARRIED	SINGLE	DIVORCED	WIDOWED			INSURED'S I.D. NO.		
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	DATE						SECON	DARY CARRIER	
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	ADDRESS				\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		GROUP NO.	7.5.V	
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FOR YOUR CHILD START HERE	BIRTHDATE	AGE	MALE	FEMALE	-	-	DATE OF BIRTH	RELATIONSHIP TO PATIENT	
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EMPLOYER'S NAME	Ē			PHONE NUM	NBEH				
ADDRESS		CITY		ADDRESS					
PHONE NO.				CITY			STATE	ZIP	

Please turn over and sign

1.800.925.2600

CONSENT FOR TREATMENT

1.	I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) 's dental needs.
2.	Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3.	I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4.	I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Relationship to Patient_

Patient's Signature ________Date ___

Parent/Responsible Party's Signature _