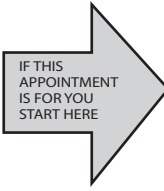


PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

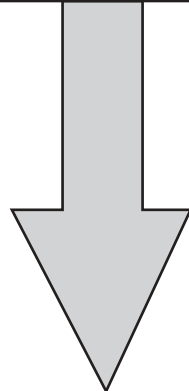
| | | | | |
|-------------------------|--------|----------|---------|----------|
| DATE | | | | 1 |
| LAST NAME | | FIRST | MI. | |
| PREFERS TO BE CALLED BY | | | | |
| ADDRESS | | | | |
| CITY | | STATE | ZIP | |
| HOME PHONE NO. | | | FAX | |
| CELL | | | EMAIL | |
| BIRTHDATE | AGE | MALE | FEMALE | |
| MARRIED | SINGLE | DIVORCED | WIDOWED | |
| SOCIAL SECURITY NO. | | | | |
| <hr/> | | | | |
| DATE | | | | |
| LAST NAME | | FIRST | MI. | |
| ADDRESS | | | | |
| CITY | | STATE | ZIP | |
| HOME PHONE NO. | | | | |
| BIRTHDATE | AGE | MALE | FEMALE | |
| SCHOOL | | GRADE | | |
| SOCIAL SECURITY NO. | | | | |



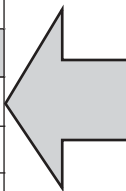
IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

PATIENT REGISTRATION

| | | |
|-------------------------------|-------------------------|----------|
| DENTAL INSURANCE | | 2 |
| PRIMARY CARRIER | | |
| INSURANCE COMPANY | | |
| GROUP NO. | | |
| EMPLOYER NAME | | |
| INSURED'S NAME | | |
| DATE OF BIRTH | RELATIONSHIP TO PATIENT | |
| INSURED'S ID. NO. | | |
| INSURED'S SOCIAL SECURITY NO. | | |
| SECONDARY CARRIER | | |
| INSURANCE COMPANY | | |
| GROUP NO. | | |
| EMPLOYER NAME | | |
| INSURED'S NAME | | |
| DATE OF BIRTH | RELATIONSHIP TO PATIENT | |
| INSURED'S ID. NO. | | |



| | | |
|---|---------------------|----------|
| ACCOUNT INFORMATION | | 4 |
| PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT | | |
| NAME | | |
| RELATIONSHIP TO PATIENT | SOCIAL SECURITY NO. | |
| ADDRESS | | |
| CITY | STATE | ZIP |
| PHONE NO. | | |
| YOU | | |
| NAME | | |
| OCCUPATION | | |
| EMPLOYERS NAME | | |
| ADDRESS | CITY | |
| PHONE NO. | FAX NO. | |
| YOUR SPOUSE | | |
| NAME | | |
| OCCUPATION | | |
| EMPLOYERS NAME | | |
| ADDRESS | CITY | |
| PHONE NO. | FAX NO. | |



| | | |
|--|---------------|----------|
| GETTING TO KNOW YOU | | 3 |
| IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE? | | |
| NAME: | RELATIONSHIP: | |
| YOU WERE 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 | | |

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 give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. 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,

Patient's Signature _____ Date _____ Witness _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____

| |
|---------------------|
| Patient Name |
| Patient Account No. |

DENTAL HISTORY

| |
|---------------|
| Medical Alert |
|---------------|

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.

What is the reason for your visit today? _____

Date of Last Dental Visit _____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays** _____

What was done at your last dental visit? _____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:

| | | |
|---|-----|----|
| Hot or cold? | Yes | No |
| Sweets? | Yes | No |
| Biting or Chewing? | Yes | No |
| Have you noticed any mouth odors or bad tastes? | Yes | No |
| Do you frequently get cold sores, blisters or any other oral lesions? | Yes | No |

Do your gums bleed or hurt? Yes No

| | | |
|--|-----|----|
| Have your parents experienced gum disease or tooth loss? | Yes | No |
| Have you noticed any loose teeth or change in your bite? | Yes | No |
| Does food tend to become caught in between your teeth? | Yes | No |

If yes, where? _____

Do You:

| | | |
|---|-----|----|
| Clench or grind your teeth while awake or asleep? | Yes | No |
| Bite your lips or cheeks regularly? | Yes | No |
| Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) | Yes | No |
| Mouth breathe while awake or asleep? | Yes | No |
| Have tired jaws, especially in the morning? | Yes | No |
| Smoke/chew tobacco? | Yes | No |

Have you ever had:

| | | |
|---|-------|----|
| Orthodontic treatment? | Yes | No |
| Oral surgery? | Yes | No |
| Periodontal treatment? | Yes | No |
| Your teeth ground or the bite adjusted? | Yes | No |
| A bite plate or mouth guard? | Yes | No |
| A serious injury to the mouth or head? | Yes | No |
| If so, please describe, including cause | _____ | |

Have you experienced:

| | | |
|--|-----|----|
| Clicking or popping of the jaw? | Yes | No |
| Pain? (joint, ear, side of face) | Yes | No |
| Difficulty in opening or closing the mouth? | Yes | No |
| Difficulty in chewing on either side of the mouth? | Yes | No |
| Headaches, neckaches or shoulder aches? | Yes | No |
| Sore muscles (neck, shoulders)? | Yes | No |

Are you satisfied with your teeth's appearance? Yes No

Would you like to keep all of your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe _____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

