MEDICAL HISTORY

Patient Name	Date of birth
Pharmacy	Emergency Contact Name & Phone

1. Physician's Name _____ Phone ( ) _____
   Have you had any medical care within the past two years? ..... Yes No
   Describe _____
2. Have you taken any medication or drugs during the past two years? ..... Yes No
3. Are you currently taking any medication, drugs, pills or herbal remedites, including regular dosages of aspirin? ..... Yes No
   If yes, please list name and dosage _____
   _____
4. Have you ever taken prescription medicatuons for weight loss (diet pills)? ..... Yes No
   If yes, did you take any of the following? (circle if yes) Fen-Phen Pondimen Redux Other
   If yes to any of the above, did you have a medical exam for heart issues? ..... Yes No
5. Have you ever taken bone loss prevention drugs such as Fosamx, Actonel, Boniva or other similar drugs? ..... Yes No
6. Are you aware of having an allergic (or adverse) reaction to any substance or medication? ..... Yes No
   If yes, please specify _____
7. Have you been a patient in the hospital during the past five years? ..... Yes No
8. Indicate which of the following you have had, or have at present. **Circle "yes" or "no" to each item.**

(circle one) Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A B C (circle)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	A.I.D.S/H.I.V. Positive	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	Cold Sores/ Fever Blisters	Yes	No
Heart Murmur	Yes	No	Emphysema	Yes	No	Blood Transfustion	Yes	No
(circle one) High/Low Blood Pressure	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
			Asthma	Yes	No	Bruise Easily	Yes	No
(circle one) Artificial Heart Valve/Pacemaker	Yes	No	(circle one) Hay Fever/Allergy/Hives	Yes	No	Liver Disease/Yellow Jaundice	Yes	No
Rheumatic Fever	Yes	No	Latex Sensitivity	Yes	No	Neurological Disorders	Yes	No
Arthritis/Rheumatism	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Cirtisone Medicine	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Swollen Ankles	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Stroke	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Kidney Trouble	Yes	No			

9. Do you have or have you had any disease, condition, or problems not listed? ..... Yes No
   If yes, please list: _____
10. **Women:** Are you pregnant or think you could be pregnant? Yes _____ Months No **Nursing?** Yes No
11. Do you use birth control prescriptions? ..... Yes No
12. Date of last dental exam _____ Last Cleaning _____ Last Full Mouth X-ray _____
14. Previous Dentist name and address and phone _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian signature _____ Date _____

PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

DATE			1
LAST NAME	FIRST	M.I	
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.			

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DATE			
LAST NAME	FIRST	M.I	
PREFERS TO BE CALLED BY			
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE NO.	CELL		
BIRTHDATE / AGE	MALE	FEMALE	
SCHOOL		GRADE	
SOCIAL SECURITY NO.			

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

DENTAL INSURANCE	2
PRIMARY CARRIER	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH / RELATIONSHIP TO PATIENT	
INSURED'S I.D. 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 I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	

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 the 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 opera tions. 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 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 _____