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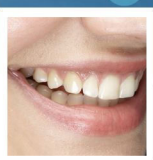

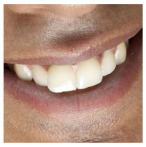

Welcome to Our Practice This confidential information will help us prepare for your visit.

Patient Name:
Title (Mr/Mrs/Ms/Dr etc):
I prefer to be addressed as:
Birthdate: SS#:
Address:
City State Zip
Family Status: Married Single Child Other
Home #: Work #:
Email:
Employer:
Address:
Occupation: There for years
Where and when is best to reach you?
How did you find out about our office?
Other family members seen by us:
Last dental visit:
Seen by Dr. for:

Spouse's Name:
Birthdate: Work #:
Address:
City State Zip
Occupation: There for years

Why have you made this dental appointment?

Why did you leave the office of your previous dentist?

Please check one box in each section

- My mouth is very comfortable.
- My mouth is moderately comfortable.
- My mouth is uncomfortable.

- I think the appearance of my smile is excellent.
- I am satisfied with the appearance of my smile.
- I would like to change my smile.
- I am unconcerned about the appearance.

- I will do whatever I must to keep my teeth.
- I want to keep my teeth but only within a certain budget of time and money.
- I am indifferent about keeping my teeth.

- I have always done what was recommended to me.
- I have not done what was recommended to me.
- I have not had dentistry recommended to me.

- I put dental care for myself and family high on my priority list.
- I put dental care low on my list.
- I have never considered where I put dental care.

- I think my present state of dental health is excellent.
- I think my present state of dental health is good.
- I think my present state of dental health is poor.

Obstacles I see to having excellent dental care for myself.....
If you select more than one of the following, please number them in order of significance with #1 being that which os most significant for you at this time.

- I see no obstacles.
- Time away from work or other obligations.
- Fear of pain, surgery, or injections.
- Fear because of past dental experiences.
- The cost of treatment.
- Other

PLEASE CONTINUE TO THE NEXT PAGE AND COMPLETE THE ADDITIONAL INFORMATION.....

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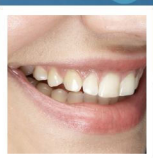
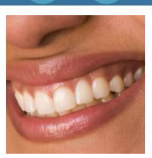
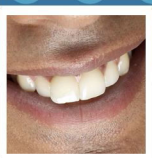

My current MEDICAL heath is:

☐ Excellent ☐ Good ☐ Poor

Are you under the care of a physician? ☐ No ☐ Yes

Physician Name:

Office Location:

Office Telephone:

List all medications you take (prescription and over the counter):

Have you ever had the following:

- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Mitral Valve prolapse
- ☐ Heart Murmur
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Hepatitus
- ☐ Kidney Problems
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Radiation Treatment
- ☐ HIV / Aids
- ☐ Shingles
- ☐ Artificial Joint
- ☐ Fever Blisters
- ☐ Cold Sores
- ☐ Artificial Valve
- ☐ Stroke
- ☐ Sinus Trouble
- ☐ Epilepsy/ Seizures
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Psychiatric Problems
- ☐ Ulcers
- ☐ Colitis
- ☐ Drug / Alcohol Dependence
- ☐ Anemia
- ☐ Asthma
- ☐ Hemophilia / Bleeding
- ☐ Arthritis
- ☐ Emphysema
- ☐ Venereal Disease
- ☐ Fainting
- ☐ Glaucoma
- ☐ Difficulty Breathing

☐ Hospitalized Date:
☐ High / Low Blood Pressure
☐ Blood Transfusion
☐ Severe or Frequent Headaches

Are you Allergic to or have difficulty with any of the following substances:

☐ Penicillin	☐ Tetracycline	☐ Latex
☐ Aspirin	☐ Codeine	☐ Dental Anesthetic
☐ Sulfa	☐ Erythromycin	☐ Metals

☐ Other Drugs:

Do you exercise regularly ☐ No ☐ Yes

If YES, what do you enjoy doing?

Do you have history of, or are you currently using tobacco products? ☐ No ☐ Yes

For Women:

Are you taking birth control pills?	☐ No	☐ Yes
Are you pregnant?	☐ No	☐ Yes
Are you nursing?	☐ No	☐ Yes

The information presented on these pages is true to the best of my knowledge. The undersigned authorizes the doctor to take X-rays, study models, photographs, or other diagnostic materials deemed appropriate by the doctor to make a thorough diagnosis of my dental health condition. I authorize the doctor to perform any and all forms of treatment, medication, and therapy which may be indicated in the connection with the services required for my dental health. I understand that the doctor will discuss treatment before it is initiated. I further authorize and consent that the doctor choose and employ such assistance as deemed fit.

I understand that the responsibility for payment for professional services provided is this office for myself or my dependants is mine, due and payable at the time services are rendered unless written financial arrangements have been made. In the event of a default, I promise to pay interest on the indebtedness, together with any collection costs and attorney fees as may be required to effect collection.

All amounts 60 days past due are assessed 1.5% per month.

SIGNED **DATE**

Thank you for filling this form out completely. If you have questions regarding this form or any aspect of our dental practice, please call.