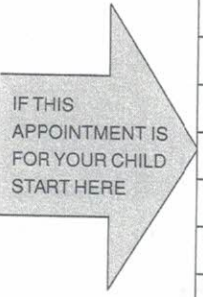


PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION



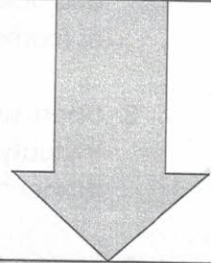
DATE				1
LAST NAME		FIRST	M.I.	
PREFERS TO BE CALLED BY				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.		FAX		
CELL		EMAIL		
BIRTHDATE	AGE	MALE	FEMALE	
MARRIED	SINGLE	DIVORCED	WIDOWED	
SOCIAL SECURITY NO.				



DATE				
LAST NAME		FIRST	M.I.	
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.		
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.		



ACCOUNT INFORMATION		4
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
YOU		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER'S 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 _____

HEALTH HISTORY

English

Patient Name: _____ Patient Identification Number: _____

Birth Date: _____

I. CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand question):

- | | | | | | |
|----|-----|----|--|--|--|
| 1. | Yes | No | Is your general health good? | | |
| 2. | Yes | No | Has there been a change in your health within the last year? | | |
| 3. | Yes | No | Have you been hospitalized or had a serious illness in the last three years?
If YES, why? _____ | | |
| 4. | Yes | No | Are you being treated by a physician now? For what? _____
Date of last medical exam? _____ Date of last Dental exam _____ | | |
| 5. | Yes | No | Have you had problems with prior dental treatment? | | |
| 6. | Yes | No | Are you in pain now? | | |

II. HAVE YOU EXPERIENCED:

- | | | | | | | | |
|-----|-----|----|--|-----|-----|----|------------------------|
| 7. | Yes | No | Chest pain (angina)? | 18. | Yes | No | Dizziness? |
| 8. | Yes | No | Swollen ankles? | 19. | Yes | No | ringing in ears? |
| 9. | Yes | No | Shortness of breath? | 20. | Yes | No | Headaches? |
| 10. | Yes | No | Recent weight loss, fever, night sweats? | 21. | Yes | No | Fainting spells? |
| 11. | Yes | No | Persistent cough, coughing up blood? | 22. | Yes | No | Blurred vision? |
| 12. | Yes | No | Bleeding problems, bruising easily? | 23. | Yes | No | Seizures? |
| 13. | Yes | No | Sinus problems? | 24. | Yes | No | Excessive thirst? |
| 14. | Yes | No | Difficulty swallowing? | 25. | Yes | No | Frequent urination? |
| 15. | Yes | No | Diarrhea, constipation, blood in stools? | 26. | Yes | No | Dry mouth? |
| 16. | Yes | No | Frequent vomiting, nausea? | 27. | Yes | No | Jaundice? |
| 17. | Yes | No | Difficulty urinating, blood in urine? | 28. | Yes | No | Joint pain, stiffness? |

III. DO YOU HAVE OR HAVE YOU HAD:

- | | | | | | | | |
|-----|-----|----|---|-----|-----|----|-----------------------------|
| 29. | Yes | No | Heart disease? | 40. | Yes | No | AIDS |
| 30. | Yes | No | Heart attack, heart defects? | 41. | Yes | No | Tumors, cancer? |
| 31. | Yes | No | Heart murmurs? | 42. | Yes | No | Arthritis, rheumatism? |
| 32. | Yes | No | Rheumatic fever? | 43. | Yes | No | Eye diseases? |
| 33. | Yes | No | Stroke, hardening of arteries? | 44. | Yes | No | Skin diseases? |
| 34. | Yes | No | High blood pressure? | 45. | Yes | No | Anemia? |
| 35. | Yes | No | Asthma, TB, emphysema, other lung diseases? | 46. | Yes | No | VD (syphilis or gonorrhea)? |
| 36. | Yes | No | Hepatitis, other liver disease? | 47. | Yes | No | Herpes? |
| 37. | Yes | No | Stomach problems, ulcers? | 48. | Yes | No | Kidney, bladder disease? |
| 38. | Yes | No | Allergies to: drugs, foods, medications, latex? | 49. | Yes | No | Thyroid, adrenal disease? |
| 39. | Yes | No | Family history of diabetes, heart problems, tumors? | 50. | Yes | No | Diabetes? |

IV. DO YOU HAVE OR HAVE YOU HAD:

- | | | | | | | | |
|-----|-----|----|-------------------------|-----|-----|----|---------------------|
| 51. | Yes | No | Psychiatric care? | 56. | Yes | No | Hospitalization? |
| 52. | Yes | No | Radiation treatments? | 57. | Yes | No | Blood transfusions? |
| 53. | Yes | No | Chemotherapy? | 58. | Yes | No | Surgeries? |
| 54. | Yes | No | Prosthetic heart valve? | 59. | Yes | No | Pacemaker? |
| 55. | Yes | No | Artificial joint? | 60. | Yes | No | Contact lenses? |

V. ARE YOU TAKING:

- | | | | | | | | |
|-----|-----|----|--|-----|-----|----|----------------------|
| 61. | Yes | No | Recreational drugs? | 63. | Yes | No | Tobacco in any form? |
| 62. | Yes | No | Drugs, medications, over-the-counter medicines
(including Aspirin), natural remedies? | 64. | Yes | No | Alcohol? |

Please list: _____

VI. WOMEN ONLY:

- | | | | | | | | |
|-----|-----|----|--|-----|-----|----|-----------------------------|
| 65. | Yes | No | Are you or could you be pregnant or nursing? | 66. | Yes | No | Taking birth control pills? |
|-----|-----|----|--|-----|-----|----|-----------------------------|

VII. ALL PATIENTS:

67. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If so, please explain: _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature: _____ Date: _____

RECALL REVIEW:

1. Patient's signature _____ Date: _____

2. Patient's signature _____ Date: _____

3. Patient's signature .. . _____ Date: _____

THE CENTRE FOR CONTEMPORARY DENTISTRY

I acknowledge notice of this office's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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