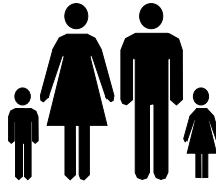


ADVANCED FAMILY DENTISTRY



PATIENT INFORMATION

TODAYS DATE _____

NAME _____ SOC.SEC. # _____ - _____ - _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ HOME PHONE _____

SEX _____ AGE _____ BIRTHDATE _____ - _____ - _____ MARITAL STATUS _____

PATIENT EMPLOYED BY _____ OCCUPATION _____

BUSINESS ADDRESS _____

BUS.PHONE _____ CELL PHONE _____

IN CASE OF EMERGENCY WHO SHOULD WE CONTACT? _____

WHOM SHOULD WE THANK FOR REFFERING YOU TO OUR PRACTICE?

PRIMARY INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT _____

RELATION OT PATIENT _____ BIRTHDATE _____ - _____ - _____ SS# _____ - _____ - _____

ADDRESS (IF DIFFERENT FROM PATIENTS) _____

CITY _____ STATE _____ ZIP _____ PHONE _____

PERSON RESPONSIBLE EMPLOYED BY _____ OCCUPATION _____

BUSINESS ADDRESS _____ BUS.PHONE _____

INSURANCE COMPANY _____ GROUP # _____

NAME OF OTHER DEPENDENTS COVERED UNDER THIS PLAN _____

DENTAL HISTORY

REASON FOR TODAY'S VISIT _____

FORMER DENTIST _____ ADDRESS _____

DATE OF LAST DENTAL CARE _____ REASON _____

PAST MAJOR DENTAL TREATMENT (SURGERY, BRACES, ETC) _____

HOW OFTEN DO YOU BRUSH? _____ FLOSS _____

WHAT DID YOU LIKE MOST ABOUT ANY FORMER DENTAL OFFICE? _____

WHAT DID YOU LIKE LEAST ABOUT GOING TO THE DENTIST? _____

CHECK IF YOU HAVE HAD PROBLEMS WITH ANY OF THE FOLLOWING:

- | | | |
|--|--|---|
| <input type="checkbox"/> BAD BREATH | <input type="checkbox"/> GRINDING TEETH | <input type="checkbox"/> SENSITIVE TO HOT OR COLD |
| <input type="checkbox"/> BLEEDING GUMS | <input type="checkbox"/> BROKEN FILLINGS | <input type="checkbox"/> SENSITIVE WHEN BITING |
| <input type="checkbox"/> SORE JAW | <input type="checkbox"/> SORES IN MOUTH | <input type="checkbox"/> SENSITIVE TO SWEETS |

MEDICAL HISTORY

PHYSICIAN'S NAME _____ ADDRESS _____

HAVE YOU HAD ANY SERIOUS ILLNESSES OR OPERATIONS? _____

DO YOU HAVE ANY MEDICAL CONDITIONS WE SHOULD KNOW ABOUT? _____

PLEASE CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

- | | | |
|--|---|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> DIABETES | <input type="checkbox"/> LIVER DISEASE |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> MITRAL VALVE PROLAPSE |
| <input type="checkbox"/> ARTHRITIS, RHEUMATISM | <input type="checkbox"/> FAINING | <input type="checkbox"/> PACEMAKER |
| <input type="checkbox"/> ARTIFICIAL HEART VALVES | <input type="checkbox"/> HEADACHES (MIGRANES) | <input type="checkbox"/> RADIATION TREATMENT |
| <input type="checkbox"/> ARTIFICIAL JOINTS | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> RESPIRATORY DISEASE |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> HEART PROBLEMS | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> BLOOD DISEASE | <input type="checkbox"/> HEMOPHILIA | <input type="checkbox"/> SHORTNESS OF BREATH |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> HEPATITIS (TYPE _____) | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> CHEMICAL DEPENDENCY | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> THYROID PROBLEMS |
| <input type="checkbox"/> CHEMOTHERAPY | <input type="checkbox"/> HIV POSITIVE | <input type="checkbox"/> TOBACCO HABIT |
| <input type="checkbox"/> CIRCULATORY PROBLEMS | <input type="checkbox"/> JAW PAIN | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> CORTISONE TREATMENTS | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> VENEREAL DISEASE |

(WOMEN) ARE YOU PREGNANT? _____ NURSING? _____ TAKING BIRTH CONTROL PILLS? _____

MEDICATIONS (PLEASE LIST) _____

ALLERGIES _____

AUTHORIZATION

I AUTHORIZE MY INSURANCE COMPANY TO PAY TO THE DENTIST OR DENTAL GROUP ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS. I AUTHORIZE THE DENTIST TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE.

I UNDERSTAND PAYMENT IS DUE AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

SIGNATURE _____ DATE _____