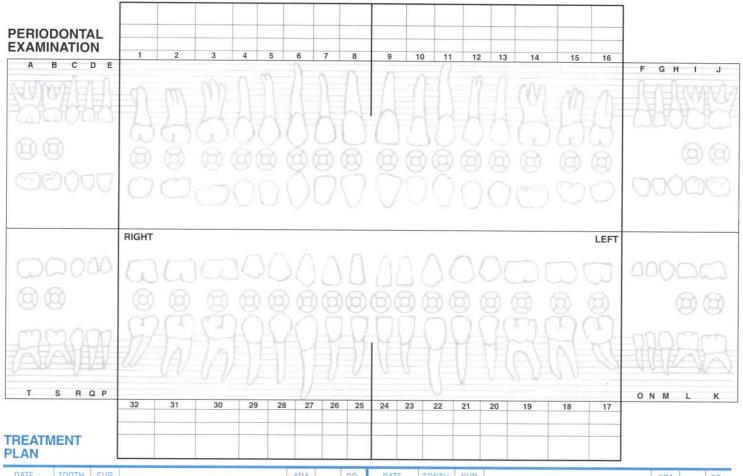
ABC HEALTH HISTORY & REGISTRATION

Patient Number_

			FAI	IENT INF	ORMATION				
PATIENT'S NAME Last		rst						E AGI	
Soc. Sec. #	If Patie	ent is a f	Minor, giv	e Parent's or G	uardian's Name		TODA	AY'S DATE	
Who May We Thank for Referring You to	our Office?				Reason for this	Visit			
		RESI	PONS	IBLE PAF	RTY INFORMA	ATION			
NAME Last			First			Middle	Initial	MARITAL STATUS	
RESIDENCE Street									
MAILING ADDRESS Street —									
HOW LONG AT THIS ADDRESS		H	OME PH	ONE		CE	LL PHONE		
WORK PHONE									
PREVIOUS ADDRESS (if less than 3 yrs.)	Street			City		State	Zip	How Long	
SOCIAL SECURITY #	BIR	THDATE			DRIVER'S LICENSE #		RELATION	TO PATIENT	
EMPLOYER				OCCUPATIO	N		NO.	YEARS EMPLOYED	
DECDONCID	LE PARTY'S SPO	IICE			EMERCENC	VINEORMAT	ION: BELATIVE	NOT LIVING WITH	1 YOU
NAME	LE PARTY 5 SPO	USE			EWENGENC	TINFORMA	ION. HELATIVE	- NOT EIVING WITT	1100.
LAST	OCCUPATION		MIDDLE	1 1	NAME			RELATIONSHIP	
SOC. SEC. #	_		NO	YEARS EMPLOYED	ADDRESS			CITY, STATE	
HOME PH.					HOME PH.		CELL PH		
WORK PH.					WORK PH.				
WORK FILE	_ E WINE								AND THE
DENTAL INSURANCE I	INFORMATION (Pr	rimary	Carrie	er)	If you have double	dental insuran	ce coverage, comp	lete this for the second	coverage.
Insured's Name					Insured's Name				
Insurance Co	1	E-MAIL			Insurance Co.			E-MAIL	
Insurance Co. Address					Insurance Co. Addre	ess			
Insured's Employer									
Insured's Soc. Sec. #	Grou	ıp #	Loca	al #	Insured's Soc. Sec.	#		Group # Local	#
It is important that I know is strictly confidenti	about your Medic al and will not be r	al and elease	Dental ed to an	History. The yone. Thank	se facts have a d you for taking th	lirect bearing ne time to con	on your Dental I apletely fill out to	Health. This informa his questionnaire.	tion
DENTAL HIS		YES	NO			MEDICAL HIS	TORY	YES	NO NO
HOW LONG SINCE you have seen a der			110	De mon bone		TH DDOD! EMC?			
Last COMPLETE Dental Exam, Date:	THIST?		110		any CURRENT HEALT r a PHYSICIAN'S CAR				
Last FULL MOUTH X-RAYS, DATE: (16 St	mall Films or Panoramic)			Are you unde For what?	any CURRENT HEAL r a PHYSICIAN'S CAF	RE now?			
Last FULL MOUTH X-RAYS, DATE: (16 Stree you having PROBLEMS now?	mall Films or Panoramic)			Are you unde For what? What MEDIC	any CURRENT HEAL' r a PHYSICIAN'S CAF ATIONS are you curre	RE now?			
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Last FULL MOUTH X-RAYS, DATE: (16 St. Are you having PROBLEMS now? WHAT? Is your present dental health POOR? Do you wear DENTURES? (Partials or Fi. Are you UNHAPPY with your dentures? Would you like to know more about PERMANENT REPLACEMENTS? Are you APPREHENSIVE about dental tr. Have you had any PERIODONTAL (GUN Do your gums BLEED, or feel TENDER of Are your teeth SENSITIVE to hot, cold, s. Are you UNHAPPY with the APPEARAN. Are you aware of GRINDING or CLENCH Do you have HEADACHES, EARACHES, Have you worn BRACES on your teeth (CDO you have DISCOLORED teeth that bot would you like your smile to LOOK BETT	reatment? I) treatments? I) treatments? Or IRRITATED? weets, pressure? (circle) CE of your teeth? HING your teeth? ORTHODONTICS) Other you? TER or DIFFERENT?			Are you unde For what? What MEDIC. Have you eve (Brand names inc Are you PRE Do you use PLEASE Y AIDS/HIV Pos. Anaphylaxis Anemia Arthritis (Rheum; Artificial heart v Artificial pints Asthma Atopic (Allergy Pr Back problems Blood disease	ATIONS are you currer taken Fen-Phen/Rect raken Fen-Phen/Rect rused a BISPHOSPH lude Fosamax, Actonel, Ate GNANT? CIGARS/CIGARET SOR NO OF THE FOYES NO	ntly taking? ntly taking? flux? IONATE MEDICA IONATE MEDICA IONATE MEDICA IONATE MEDICA IONATE MEDICA IONATE MEDICA Fainting Food allergies Glaucoma Heard murmur Heart problems (p) Hemophilia (Abnorm Herpes Hepatitis	HEWING TOBACC HYOU HAVE HAD, 0 YES NO GROUP HAVE HAD, 0 HAVE HAD,	CO? (circle) R PRESENTLY HAVE: Psychiatric care Rapid weight gain/loss Radiation treatment Respiratory disease Rheumatic/scarlet fever Shingles Shortness of breath Skin rash Spina Bifida Stroke Surgical implant Swelling of feet or ankles Thyroid disease or malfunction	YES NO
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Last FULL MOUTH X-RAYS, DATE: (16 Stock Are you having PROBLEMS now? WHAT? Is your present dental health POOR? Do you wear DENTURES? (Partials or Fixer You UNHAPPY with your dentures? Would you like to know more about PERMANENT REPLACEMENTS? Are you APPREHENSIVE about dental fixer You apprehensive about dental fixer You apprehensive about Are you had any PERIODONTAL (GUND Do your gums BLEED, or feel TENDER of Are you under You with the APPEARAN Are you aware of GRINDING or CLENCHDO you have HEADACHES, EARACHES, Have you worn BRACES on your teeth (CDO you have DISCOLORED teeth that be Would you like your smile to LOOK BETT DO you REGULARLY use DENTAL FLOST Name of Previous Dentist: City: How do you feel about your teeth? Please RANK the following in the KEEP YOU FROM have FEAR of pain ₱	mall Films or Panoramic) ull) reatment? I) treatments? or IRRITATED? weets, pressure? (circle) CE of your teeth? HING your teeth? HING your teeth? ORTHODONTICS) other you? TER or DIFFERENT? SS? State: the order in which they would ing dental treatment.			Are you unde For what? What MEDIC. Have you eve (Brand names inc Are you PRE. Do you use PLEASE Y Y AIDS/HIV Pos. Anaphylaxis Anemia Arthritis (Rheumi Artificial heart v Artificial points Asthma Atopic (Allergy Pr Back problems Blood disease Cancer Chemical deper Chemical deper Chemical deper Cough up blood Diabetes Epilepsy ARE YOU ALL! Aspirin Nitrous Oxide Are you awar If yes, please	ATIONS are you currer taken Fen-Phen/Rect raken Fen-Phen/Rect rake	ntly taking? ntly taking? ntly taking? iux? IONATE MEDICA ivia. Didronel and Bor TES, PIPE or C LLOWING WHICH Fainting Food allergies Glaucoma Headaches Heart murmur Heart problems (pi Hemophilia (Abnorm Herpes Hepatitis High blood pressur Jaw pain Kidney disease or m Liver disease Material allergies (intex wood, metal, cher Mitral valve prolaps Nervous problems Pacemaker/heart st. REACTED ADVERS hetic Er ny other medicati	HEWING TOBACC HYOU HAVE HAD, O YES NO GRAPH AND TOBACCO HOUSE HAD TO TOBACCO HOUSE HAD TO TOBACCO HOUSE HAD TO TOBACCO HOUSE HAD TOBACCO H	CO? (circle) R PRESENTLY HAVE: Psychiatric care Rapid weight gain/loss Radiation treatment Respiratory disease Rheumatic/scarlet fever Shingles Shortness of breath Skin rash Spina Bifida Stroke Surgical implant Swelling of feet or ankles Thyroid disease or malfunction Tobacco habit Tonsilitis Tuberculosis Ulcer/Colitis Venereal disease OLLOWING MEDICATIONS? Latex (balloons, gloves, etc.)	YES 8000000000000000000000000000000000000

DIAGNOSIS: MISSING TEETH and EXISTING PROBLEMS



DATE DIAGNOSED	TOOTH #	SUR- FACE	DESCRIPTION OF SERVICE	ADA CODE	FEE	CO- PAY	DATE DIAGNOSED	TOOTH #	SUR- FACE	DESCRIPTION OF SERVICE	ADA CODE	FEE	CO- PAY
			EXAMINATION										
			X-RAY: PANORAMIC: FMX: BWX:										
			DIAGNOSTIC MODELS										
			PROPHYLAXIS (CLEANING)										
			QUADRANTS SCALING & CURETTAGE										
			NITROUS-OXIDE GAS										
												-	

COMPLETED TREATMENT

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TSRQP	32 31 30	29 28 27 26 2	5 24 23 22	21 20 19	18 17	ONMLK
GINGIVAL INFLAMMATION:	ITIAL PERIODONTAL EXA		X-RAYS TAKEN:	INITIAL X-F □ FM-PAS □ BW	X PANO.	□ OTHER
SOFT PLAQUE BUILDUP:	□ Slight □ Mo		A-HATS TAKEN,	□ FIVI-FAS □ BVV	A LI PANU.	
HARD CALCULUS BUILDUP:	☐ Light ☐ Mo		☐ NO BONE LOSS		UR	QUADRANTS UL LR LL
STAINS:	☐ Light ☐ Mo		☐ SLIGHT BONE LO	SS (04600)		
HOME CARE EFFECTIVENESS	S: Good	□ Poor	☐ MODERATE BONE			
PERIODONTAL CONDITION:	☐ Good ☐ Fair		☐ MAJOR BONE LO			
PERIODONTAL DIAGNOSIS:	□ Normal □ Gin		☐ BEGINNING FURC			
PERIODONTITIS: MUCOGINGIVAL DEFECTS #8	☐ Early ☐ Mod	derate	□ ADVANCED FURC □ OTHER:	ATTUN (04800)		
WOODGINGIVAL DEFECTO #3				NDF.		
	CLINICAL DATA:		Teeth Upper	Lower	PERIODO	ONTAL SCREENING &
OCCLUSION: Class I	□ Class II □ Class III □ C		Cents			RECORDING
T.M.J. EXAM: Normal	☐ Popping ☐ Deviation	☐ Tooth Wear ☐ Pain	Lats			
	INITIAL SOFT TISSUE EX	AM:	Cusp Posts			
☐ Lips ☐ Floor of Mo			1 0313			MONTH DAY YEAR
			BARN		PROSTHESIS:	2 (10 (20) 20)
	TIENT'S TREATMENT DECI	SIUNS:	MAX:	DATE PLACED:		ONDITION:
☐ DOCUMENTATION OF DEN	X. RECOMMENDATIONS AND CON	ICENTS TO TV (ALTERNA	MAND:	DATE PLACED: _		ONDITION:
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	OR PARTIAL TX. INFORMED OF CO	INSEQUENCES AND RISKS	PERIO:	ORTHO:		NDO:
INVOLVED.			ORAL SURG:	MD:	0	THER:
		NO	TES			

CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports may be obtained.

PATIENT Signature (Parent of Child)	Date:	DENTIST Signature	

PERIODIC EXAMINATION HEALTH HISTORY UPDATE

Date:				CURRENT MEDICATIONS:						
Health Change	es:									
Blood Pressur	re:		CANCER EXAM	Normal Lesion:	Hyg/As	st:	Dr			
	☐ No ☐ No ☐ No ☐ No	□ Lt. □ Lt. □ Lt. □ Lt.	Mod. Hvy. Mod. Hvy. Mod. Hvy. Mod. Hvy. Mod. Hvy.	TMJ: ☐Asymptomatic ☐Symptoms HOMECARE: BRUSH: G F P FLOSS: G F P ☐ Main PERIO DIAG: ☐Normal ☐ Gingivitis ☐Early Perio ☐ Mod. Perio ☐ Adv. INSTRUCTIONS: ☐Brush ☐Floss ☐Perio Aid ☐ Other: ☐ Prophylaxis: ☐Fluoride Tr. ☐ Perio Pro. ☐ Check Next Appt:		PERIO	DONTAL SO		NG &	
Patient Signat	ure:		would	Trophysian Endone in Eronome. Editoria in Eronome		SEXTANT SCORE	M		D	
1000 HOURS OF 101/2	.010.					SEXTANT SCORE	M		U	т.
Date:				CURRENT MEDICATIONS:			_			
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Blood Pressur Stain:	re: \[\] No	□Lt.	CANCER EXAM □ Mod. □ Hvy.	Normal Lesion:	Hyg/As		Dr			
Calculus: Plaque:	□ No □ No □ No	□Lt. □Lt. □Lt.	Mod. Hvy. Mod. Hvy. Mod. Hvy. Mod. Hvy.	HOMECARE: BRUSH: G F P FLOSS: G F P ☐ Main PERIO DIAG: ☐ Normal ☐ Gingivitis ☐ Early Perio ☐ Mod. Perio ☐ Adv. INSTRUCTIONS: ☐ Brush ☐ Floss ☐ Perio Aid ☐ Other: ☐ Prophylaxis: ☐ Fluoride Tr. ☐ Perio Pro. ☐ Check Next Appt: ☐ Prophylaxis: ☐ Fluoride Tr. ☐ Perio Pro. ☐ Check Next Appt: ☐ Prophylaxis: ☐ Fluoride Tr. ☐ Perio Pro. ☐ Check Next Appt: ☐ Prophylaxis: ☐ Fluoride Tr. ☐ Perio Pro. ☐ Check Next Appt: ☐ Prophylaxis: ☐ Fluoride Tr. ☐ Perio Pro. ☐ Check Next Appt: ☐ Prophylaxis: ☐ Fluoride Tr. ☐ Perio Pro. ☐ Check Next Appt: ☐ Prophylaxis: ☐ Fluoride Tr. ☐ Perio Pro. ☐ Check Next Appt: ☐ Prophylaxis: ☐ Fluoride Tr. ☐ Perio Pro. ☐ Check Next Appt: ☐ Prophylaxis: ☐ Fluoride Tr. ☐ Perio Pro. ☐ Check Next Appt: ☐ Prophylaxis: ☐ Fluoride Tr. ☐ Perio Pro. ☐ Check Next Appt: ☐ Prophylaxis: ☐ Fluoride Tr. ☐ Perio Pro. ☐ Check Next Appt: ☐ Prophylaxis: ☐ Fluoride Tr. ☐ Perio Pro. ☐ Check Next Appt: ☐ Prophylaxis: ☐ Fluoride Tr. ☐ Perio Pro. ☐ Check Next Appt: ☐ Prophylaxis: ☐ Fluoride Tr. ☐ Perio Pro. ☐ Check Next Appt: ☐ Prophylaxis: ☐ Fluoride Tr. ☐ Perio Pro. ☐ Check Next Appt: ☐ Prophylaxis: ☐ Fluoride Tr. ☐ Perio Pro. ☐ Check Next Appt: ☐ Prophylaxis: ☐ Fluoride Tr. ☐ Perio Pro. ☐ Check Next Appt: ☐ Prophylaxis: ☐ Fluoride Tr. ☐ Fl		PERIO	RECORD		NG &	
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