

Patient Registration & Dental History

Medical History

Physician's Name _____ Date of last visit _____

Have you ever taken any of the drugs collectively referred to as "fen-phen?" These include combinations of Lonimin, Adipex, Fastin (brand names for phentermine), Podimin and Redux. Yes No

Have you had any serious illnesses or operations? Yes No If yes, please describe _____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____

(Women only) Are you pregnant, nursing or taking birth control pills? _____

Check to indicate if you have any of the following:

- | | | | |
|--|--|--|--|
| Anemia <input type="checkbox"/> | Cough, persistent <input type="checkbox"/> | Jaw Pain <input type="checkbox"/> | Sinus Trouble <input type="checkbox"/> |
| Arthritis, Rheumatism <input type="checkbox"/> | Diabetes <input type="checkbox"/> | Kidney Disease <input type="checkbox"/> | Skin Rash <input type="checkbox"/> |
| Artificial Heart Values <input type="checkbox"/> | Emphysema <input type="checkbox"/> | Liver Disease <input type="checkbox"/> | Special Diet <input type="checkbox"/> |
| Artificial Joints <input type="checkbox"/> | Epilepsy <input type="checkbox"/> | Low Blood Pressure <input type="checkbox"/> | Stroke <input type="checkbox"/> |
| Asthma <input type="checkbox"/> | Fainting or dizziness <input type="checkbox"/> | Mitral Value Prolapse <input type="checkbox"/> | Swollen Feet <input type="checkbox"/> |
| Back Problems <input type="checkbox"/> | Glaucoma <input type="checkbox"/> | Nervous Problems <input type="checkbox"/> | Swollen Neck Glands <input type="checkbox"/> |
| Bleeding abnormally <input type="checkbox"/> | Headaches <input type="checkbox"/> | Pacemaker <input type="checkbox"/> | Thyroid Problems <input type="checkbox"/> |
| Blood Disease <input type="checkbox"/> | Heart Murmur <input type="checkbox"/> | Psychiatric Care <input type="checkbox"/> | Tonsillitis <input type="checkbox"/> |
| Cancer <input type="checkbox"/> | Heart Problems <input type="checkbox"/> | Radiation Treatment <input type="checkbox"/> | Tuberculosis <input type="checkbox"/> |
| Chemical Dependency <input type="checkbox"/> | Hepatitis <input type="checkbox"/> | Respiratory Disease <input type="checkbox"/> | Tumor or growth <input type="checkbox"/> |
| Chemotherapy <input type="checkbox"/> | Herpes <input type="checkbox"/> | Rheumatic Fever <input type="checkbox"/> | Ulcer <input type="checkbox"/> |
| Circulatory Problems <input type="checkbox"/> | High Blood Pressure <input type="checkbox"/> | Scarlet Fever <input type="checkbox"/> | Venereal Disease <input type="checkbox"/> |
| Cortisone Treatments <input type="checkbox"/> | HIV/ AIDS <input type="checkbox"/> | Shortness of Breath <input type="checkbox"/> | Weight Loss <input type="checkbox"/> |

Medications

Allergies

Smile Survey

In a recent study conducted by the ADA, 99.7% of all Americans believe a smile is an important social asset.

1. On a scale of 1-10, how would you rate your smile? _____
2. Would you like to have whiter, straighter teeth? Yes No
3. If we could straighten your teeth without metal braces, would you be interested? Yes No

HIPAA Privacy Statement, Assignment and Release

I certify that I, and/or my dependents, have insurance coverage and assign directly to Prudential Dental Associates all insurance benefits, if any, otherwise to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Prudential Dental Associates may use my health care information and may disclose such information to the above-named insurance company for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I read the Notice of Privacy and acknowledge that I have been fully informed of all my rights.

I read the Financial Policy for Prudential Dental Associates and understand that I will be charged a \$75 cancellation fee for any appointment cancelled by me less than 48 hours before the scheduled appointment.

Signature of Patient, Parent or Guardian _____ Please print name _____ Date _____

Doctor's signature _____ Date _____

Please complete both sides