Patient Name:_____
Soc. Sec. #:_____
Address:_____
_____
Acct.#:_____
Age:_____ Height:_____ Weight:_____
DOB:_____
Phone #:_____

MEDICAL HEALTH HISTORY

I. Circle Appropriate Answer (leave Blank if you do not understand question)

1- Yes No Are you in good health
2- Yes No Have you had any change in weight in the past year
3- Yes No Have you been hospitalized or had a serious illness in the last 3 years
Reason : _____
4- Yes No Are you presently under medical observation or treatment
Date of last medical treatment _____ Date of last Dental Appointment _____
5- Yes No Have you had problems with prior dental treatment?_____
Physician Name_____ Address _____
6- Yes No Are you in pain now ? Phone # ( )_____

II. Have you ever had or been diagnosed or treated for any of the following?

7-	Yes	No	Chest pain (angina)	18-	Yes	No	Dizziness
8-	Yes	No	Swollen ankles	19-	Yes	No	Ringing ears
9-	Yes	No	Shortness of breath	20-	Yes	No	Headaches
10-	Yes	No	Recent weight loss/ fever / nights sweats	21-	Yes	No	Fainting spells
11-	Yes	No	Persistent cough / Spitting blood	22-	Yes	No	Blurred vision
12-	Yes	No	Bleeding problems	23-	Yes	No	Seizures / Epilepsy
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 stool	26-	Yes	No	Dry mouth
16-	Yes	No	Frequent vomitting / 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 any of the following ?

29-	Yes	No	Heart disease	40-	Yes	No	AIDS / ARC / HIV / Infection
30-	Yes	No	Heart attack / Heart defects	41-	Yes	No	Tumors / Cancer
31-	Yes	No	Heart murmur / Mitral Valve Prolapse	42-	Yes	No	Arthritis / Rheumaticism
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 / Blood disease
35-	Yes	No	TB / Emphysema / Other lung diseases	46-	Yes	No	VD (Syphilis / Gonorrhea)
36-	Yes	No	Hepatitis / Other liver diseases / Jaundice	47-	Yes	No	Herpes
37-	Yes	No	Stomach problems / Ulcers	48-	Yes	No	Kidney / Bladder disease
38-	Yes	No	ALLERGIC to: Drugs/ Foods/ Medications/ Ot	49-	Yes	No	Thyroid / Adrenal disease
39-	Yes	No	Family history of diabetes / Heart disease	50-	Yes	No	Diabetes

IV. Do you have or have had any of the following ?

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. Do you use any of the following ?

61-	Yes	No	Recreational drugs	63-	Yes	No	Tobacco in any form
62-	Yes	No	Drugs / Medicines (including aspirin) List _____	64-	Yes	No	Alcohol

VI. Women only

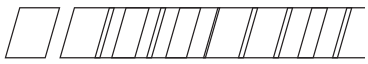
65-	Yes	No	Are you or could you be pregnant	66-	Yes	No	Taking birth control pills

VII. All Patients

67- Yes No To the best of your knowledge and belief do you have or have you had any disease, disorder or condition not listed above ? _____

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 _____



How did you hear about our office? _____

Last Name _____

First Name _____

Address _____

City _____ State _____ Zip _____

M or F _____ Single, Married, Divorced, Widowed

Patient D.O.B. _____ Age _____

Phone # _____ Work # _____

Cell # _____ Emergency # _____

Primary Insurance Name _____

Subscribers Name _____ Single, Married, Divorced, Widowed

Subscribers S.S # _____ D.O.B. _____ Age _____ M or F

Employer _____

Employer Address _____

Relationship to Patient? _____

City _____ State _____ Zip _____

Secondary Insurance Name _____

Subscribers Name _____ Single, Married, Divorced, Widowed

Subscribers S.S.# _____ D.O.B. _____ Age _____ M or F

Employer _____

Employer Address _____

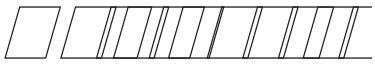
City _____ State _____ Zip _____

Relationship to Patient? _____

The Insurance co-payment, which is your responsibility, will be due at time of treatment. Insurance payment from your insurance company is based on their fee schedule, not ours. Sometimes their fees are different giving you a balance due from our office. If this happens we will bill you for that balance.

I (the patient) assume full responsibility for all dental work performed. The completion of all dental insurance forms is a service, which the dental office offers, however, the final responsibility for collecting from the insurance company is mine. *I assign benefit payment to the above named dental office for treatment performed while a patient at this office.*

Signature _____ **Date** _____



Patient Name: _____

Dental History Questionnaire

Please take the time to complete the following questions so that we may better meet your dental needs.

Other than cleaning and exam, what is your primary reason for visiting today?

_____

Would you be interested in a free consultation exam to discuss possible treatment options to improve your smile?	Yes	No
Are you interested in whitening your teeth?	Yes	No
Do you use tobacco?	Yes	No
When was your last dental cleaning?	_____	

Are any specific teeth sensitive to:

Hot?	Yes	No
Cold?	Yes	No
Biting/Chewing?	Yes	No

Please list which teeth are **currently** sensitive (upper left molar, lower front etc.) _____

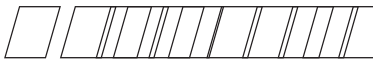
Have you ever had in the **past** or do you **currently** have:

Orthodontic Treatment?	Yes	No
Nightguard made by a dentist?	Yes	No
A gum infection or treatment?	Yes	No
Oral Surgery?	Yes	No
Serious injury to your teeth, jaw, or gums?	Yes	No
Oral Cancer?	Yes	No

Bruxism is a very common subconscious habit of clinching and grinding one's teeth that leads to damage of teeth, their nerves, and supporting tissues (gums, jaws, muscles).

Do you clinch and/or grind your teeth?	Yes	No
Have you ever had a cracked or chipped tooth?	Yes	No
Have you ever had prolonged sensitivity following dental fillings and/or crowns?	Yes	No
Are your teeth ever sensitive without an identifiable reason?	Yes	No
Do you have TMJ disorder or jaw muscle pain?	Yes	No

Whom may we thank for referring you? _____



HIPPA DISCLOSURE AUTHORIZATION FORM

Full Name _____

I hereby authorize Main Dental to use or disclose my

protected health information related to Dental Treatment

to _____ for the following purpose:
(Recipient)

_____

_____

- I understand that I may inspect or copy the protected health information described by this authorization.
- I understand that, at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my health care will not be affected if I refuse to sign this form.
- I understand that information used or disclosed, pursuant to this authorization, could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

_____ _____
Date Signature of Individual or Representative

_____
Authority or Relationship to Individual, if Representative

EXPIRATION DATE: This authorization will expire on _____
If no date or event is stated, the expiration date will be six years from the date of this authorization.

COPY PROVIDED: The subject of this authorization shall receive a copy of this authorization, when signed.