

Chart #:

FOR OFFICE USE ONLY

## PATIENT REGISTRATION

### PATIENT INFORMATION

**Patient's Name:** \_\_\_\_\_ Date: \_\_\_\_\_  
Last, First MI (Preferred Name)  
**Address:** \_\_\_\_\_  
Street Apartment #  
City State Zip Code  
**Email:** \_\_\_\_\_ **Gender:**  Male  Female **Family Status:**  Single  Married  Child  
**Social Security #:** \_\_\_\_\_ **Medicaid ID:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_  
**Drivers License #** \_\_\_\_\_ **\*\*Office Use only: Copy in file?**  Yes  No

**\*\*HIPAA\*\*:** Do we have permission to leave appointment, billing or dental information on your answering machine, voicemail or e-mail at the following numbers? Please check "Yes" or "No" for each contact number.

**DO YOU NEED COMMUNICATION ASSISTANCE**  Yes Please explain \_\_\_\_\_  
 NCAN (No communication Assistance needed)

**Home Phone:** \_\_\_\_\_  Yes  No Best time to call: \_\_\_\_\_  
**Work Phone:** \_\_\_\_\_ Ext: \_\_\_\_\_  Yes  No Best time to call: \_\_\_\_\_  
**Cell Phone:** \_\_\_\_\_  Yes  No Best time to call: \_\_\_\_\_  
**Cell Text Message:** \_\_\_\_\_  Yes  No  
**E-mail:** \_\_\_\_\_  Yes  No  
**Fax:** \_\_\_\_\_  Yes  No

### RESPONSIBLE PARTY/GUARANTOR INFORMATION

Only if the person responsible for this account is NOT the patient, complete the following information for the Guarantor:

**Guarantor Name:** \_\_\_\_\_  
**Relationship to Patient:**  Self  Spouse  Child  Other \_\_\_\_\_  
**Gender:**  Male  Female **Family Status:**  Married  Single  Divorced  Child  Other \_\_\_\_\_  
**Address:** \_\_\_\_\_  
Street City State Zip Code  
**Social Security #:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_  
**Drivers License #** \_\_\_\_\_ **\*\*Office Use only: Copy in file?**  Yes  No  
**Phone Numbers:** Home: \_\_\_\_\_ Work: \_\_\_\_\_ Ext: \_\_\_\_\_  
Cell: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_  
**Employer Name:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_  
**Employers Address:** \_\_\_\_\_  
Street City State Zip Code Phone

### REFERRAL INFORMATION

How did you learn about, or who referred you to, our dental office?  Patient/friend  Our Staff,  Another Dental Office,  
 Yellow Pages,  Insurance Plan,  Newspaper,  TV,  Website,  Newsletter,  School,  Your employer  
 Direct Mail Postcard  Other \_\_\_\_\_

Name of person or dental or medical office who referred you: \_\_\_\_\_  
Please indicate your preferred dentist or hygienist in our office: \_\_\_\_\_

## INSURANCE INFORMATION

### Primary Insurance

Name of Primary Subscriber/Insured: \_\_\_\_\_ Is the insured a patient?  Yes  No

Relationship to Patient:  Self  Spouse  Child  Other \_\_\_\_\_  
Last First MI

Insured's Social Security # \_\_\_\_\_ Birth Date: \_\_\_\_\_ Date Employed \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street City State Zip Code

Insured's Employer Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Insurance Carrier/Plan Name: \_\_\_\_\_ Insurance Group #: \_\_\_\_\_ Insurance ID#: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_  
Street City State Zip Code Phone

### Medical Insurance

Name of Primary Subscriber/Insured: \_\_\_\_\_ Is the insured a patient?  Yes  No

Relationship to Patient:  Self  Spouse  Child  Legal Guardian  Other \_\_\_\_\_  
Last First MI

Insured's Social Security # \_\_\_\_\_ Birth Date: \_\_\_\_\_ Date Employed \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street City State Zip Code

Insured's Employer Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Insurance Carrier/Plan Name: \_\_\_\_\_ Insurance Group #: \_\_\_\_\_ Insurance ID#: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_  
Street City State Zip Code Phone

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

Dentist's Signature

**TERMS AND CONDITIONS OF SERVICE**

In consideration of all services provided by Sage Dental Group of Florida, PLLC, and its affiliated dental practices doing business as Sage Dental and their employees and contractors, or by Sage Dental Group of Georgia, LLC, and its affiliated dental practices and their employees and contractors (individually and collectively, the "Dental Group"), the undersigned hereby acknowledges and agrees on behalf of himself or herself, and on behalf of his or her children, dependents, and other persons for whom he or she serves as guarantor (collectively, "Dependents"), with the following terms and conditions of service:

**Medical Information.** The undersigned hereby certifies that all information provided to the Dental Group is true, correct and complete and agrees to promptly inform the Dental Group of any changes in any information (including regarding any Dependent). The Dental Group is authorized to use and disclose to any insurance, billing, management or processing company, agency or organization any health care information and medical records relating to the undersigned or any Dependent to obtain payment for services, determine insurance benefits, or otherwise as required by law. The Dental Group is authorized to contact the undersigned at any telephone number provided above (unless otherwise revoked in writing) to discuss this form and any billing, treatment, or other matter related to any dental treatment (including for any Dependent).

**Treatment; Informed Consent.** The undersigned authorizes the Dental Group and any treating dentist, hygienist, and staff member to perform all treatment described in any treatment plan (and including all other services determined by such dentist to be necessary or appropriate in connection with such treatment plan) accepted by undersigned for himself or herself or any Dependent. Dentistry is a biological procedure and not an exact science; therefore, despite the highest standard of care, no guarantee is or can be given by the Dental Group or any dentist or any other person employed or contracted by the Dental Group regarding any treatment or the results that may be obtained. The patient must comply with all specified appointments, procedures, and continuing care, and failure to do so will adversely affect the patient's treatment often necessitating additional required treatment (or retreatment) with additional fees. Failure to show within 15 minutes of the scheduled time for, or provide at least 48 hours advance notice of cancellation of, any appointment for any reason will result in a broken appointment fee. The Dental Group does not exercise control over the professional services of any of its treating dentists; therefore, the undersigned shall solely hold the treating dentist responsible for any treatment performed (including, without limitation, treatment provided under the treating dentist's supervision) and agrees to hold harmless the Dental Group and its interest holders, members, managers, officers, directors, owners, affiliates, employees, agents, contractors, and all other persons and entities under common control or ownership with the Dental Group. **Fees in treatment plans for non-insurance/discount plan patients are only valid for 30 days; all insurance/discount plan fees are subject to change at any time based upon changes in plan fee schedules or to correct errors.**

**Financial Responsibility; Insurance.** **THE UNDERSIGNED PATIENT AND GUARANTOR ASSUME FULL RESPONSIBILITY FOR PAYMENT OF ALL FEES AND CHARGES FOR ALL SERVICES OF THE DENTAL GROUP, WHETHER OR NOT COVERED BY INSURANCE. THE PATIENT'S PORTION OF ALL FEES (INCLUDING ALL DEDUCTIBLES AND CO-PAYS) IS DUE AND PAYABLE IN FULL AT THE TIME SERVICES ARE PERFORMED.** For treatment involving multiple appointments, such as a crown, root canal, denture, or implant, the entire patient portion is normally due when treatment is started. Any special financial arrangements must be made before treatment is started. All insurance, discount plans and discount coupons must be presented before treatment is started. The Dental Group submits insurance claims solely to primary dental insurance for patients' convenience and does not assume responsibility for the processing of such insurance or failure of insurance to pay for any reason. Dental insurance rarely covers all fees; estimated or preauthorized insurance benefits are not guaranteed. The undersigned agrees to pay promptly on demand any balance not paid by insurance within 60 days after the date of service. A service charge of 1½% per month (18% per annum) is charged on all balances more than 30 days past due. Insurance balances are considered past due if not paid within 60 days of the date of service. The undersigned shall pay all costs incurred by the Dental Group relating to collection of any unpaid or delinquent balance (including, without limitation, attorneys and collection agency fees, court costs, paralegals) whether or not suit is filed. The Dental Group reserves the right to terminate or deny any treatment if the patient's account is delinquent.

**Assignment of Benefits; Authorization and Release.** The undersigned hereby certifies that all insurance coverage described above is current and valid and assigns directly to the Dental Group all insurance benefits covering the undersigned or any Dependent for all services rendered. The undersigned hereby agrees that his or her signature below will be maintained "on file"; the Dental Group is authorized to use such signature on all applicable insurance claims and submissions. If any insurance payment is made to the undersigned, he or she shall immediately remit such payment to the Dental Group.

**Notice of Privacy Practices.** The undersigned has reviewed a copy of the Dental Group's Notice of Privacy Practices effective April 14, 2003, as amended.

**I have read the above terms and conditions of service by the Dental Group and understand and accept such terms:**

\_\_\_\_\_  
Signature of Patient, Parent, Legal Guardian,  
Health Care Proxy or Surrogate, or Power of Attorney

Date signed: \_\_\_\_\_

\_\_\_\_\_  
Printed name of Patient, Parent, Legal Guardian,  
Health Care Proxy or Surrogate, or Power of Attorney

Relationship to Patient: \_\_\_\_\_ Date signed: \_\_\_\_\_

\_\_\_\_\_  
Signature of Witness

Date signed: \_\_\_\_\_

\_\_\_\_\_  
Printed name of Witness

# HIPAA COMPLIANCE

## Patient Consent to Receive Mail and/or Telephone Messages

**Patient's Name:** *(Please print)*

\_\_\_\_\_  
LAST NAME                      FIRST NAME                      MIDDLE

1. Do we have your permission to send recall/treatment appointment reminders to your home? Yes \_\_\_\_ No \_\_\_\_

2. Do we have your permission to leave the following information on your home answering machine or voice mail?

Appointment Information	Yes ____	No ____
Billing Information	Yes ____	No ____
Dental/Medical Information	Yes ____	No ____

3. Do we have your permission to leave the following information on your work answering machine or voice mail?

Appointment Information	Yes ____	No ____
Billing Information	Yes ____	No ____
Dental/Medical Information	Yes ____	No ____

4. Do we have your permission to send the following information to your e-mail address provided to us on your patient registration form?

Appointment Information	Yes ____	No ____
Billing Information	Yes ____	No ____
Dental/Medical Information	Yes ____	No ____

5. Do we have your permission to send the following information to your cell phone number (including text messages) provided to us on your patient registration form?

Appointment Information	Yes ____	No ____
Billing Information	Yes ____	No ____
Dental/Medical Information	Yes ____	No ____

6. Do we have your permission to send the following information to your fax machine at the number provided to us on your patient registration form?

Appointment Information	Yes ____	No ____
Billing Information	Yes ____	No ____
Dental/Medical Information	Yes ____	No ____

7. I hereby give permission to share any information concerning me with the person(s) named below:

Name: \_\_\_\_\_ Name: \_\_\_\_\_

**DATE:** \_\_\_\_\_

**SIGNED:** \_\_\_\_\_

**WITNESS:** \_\_\_\_\_

Print Name: \_\_\_\_\_

Print Name: \_\_\_\_\_

Relationship to Patient: Self \_\_\_\_ Spouse \_\_\_\_ Parent \_\_\_\_ Child \_\_\_\_ Legal Guardian \_\_\_\_ Other: \_\_\_\_

# Health History Form

Email:  Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name:			Home Phone: <i>Include area code</i>	Business/Cell Phone: <i>Include area code</i>	
<i>Last</i>	<i>First</i>	<i>Middle</i>	( )	( )	
Address:			City:	State:	Zip:
<i>Mailing address</i>					
Occupation:			Height:	Weight:	Date of Birth:      Sex:    M    F
SS# or Patient ID:		Emergency Contact:	Relationship:	Home Phone: <i>Include area code</i>	Cell Phone: <i>Include area code</i>
				( )	( )
If you are completing this form for another person, what is your relationship to that person?					
<i>Your Name</i>			<i>Relationship</i>		
<b>Do you have any of the following diseases or problems:</b>			<i>(Check DK if you Don't Know the answer to the the question)</i>		<b>Yes No DK</b>
Active Tuberculosis.....					<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Persistent cough greater than a 3 week duration.....					<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cough that produces blood.....					<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Been exposed to anyone with tuberculosis.....					<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.</b>					

## Dental Information For the following questions, please mark (X) your responses to the following questions.

<b>Yes No DK</b>	<b>Yes No DK</b>
Do your gums bleed when you brush or floss?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have earaches or neck pains?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your mouth dry?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you brux or grind your teeth?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any periodontal (gum) treatments?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have sores or ulcers in your mouth?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you wear dentures or partials?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any problems associated with previous dental treatment?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you participate in active recreational activities?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your home water supply fluoridated?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Do you drink bottled or filtered water?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of your last dental exam:
If yes, how often? <i>Circle one:</i> DAILY / WEEKLY / OCCASIONALLY	What was done at that time?
Are you currently experiencing dental pain or discomfort?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of last dental x-rays:
What is the reason for your dental visit today?	
How do you feel about your smile?	

## Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

<b>Yes No DK</b>	<b>Yes No DK</b>
Are you now under the care of a physician?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Physician Name: <input type="text"/>	If yes, what was the illness or problem?
Phone: <i>Include area code</i> ( )	
Address/City/State/Zip: <input type="text"/>	Are you taking or have you recently taken any prescription or over the counter medicine(s)?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are you in good health?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements: _____ _____ _____
Has there been any change in your general health within the past year?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
If yes, what condition is being treated?	
Date of last physical exam: <input type="text"/>	

# Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

<i>(Check DK if you Don't Know the answer to the question)</i>		<b>Yes No DK</b>		<b>Yes No DK</b>	
Do you wear contact lenses?.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Joint Replacement.</b> Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date: _____ If yes, have you had any complications? _____					
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date Treatment began: _____					

**WOMEN ONLY** Are you:

Pregnant?.....

Number of weeks: \_\_\_\_\_

Taking birth control pills or hormonal replacement?.....

Nursing?.....

<b>Allergies.</b> Are you allergic to or have you had a reaction to: To all <b>yes</b> responses, specify type of reaction.		<b>Yes No DK</b>		<b>Yes No DK</b>	
Local anesthetics _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metals _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Latex (rubber) _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Iodine _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever/seasonal _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Animals _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.**

<b>Yes No DK</b>		<b>Yes No DK</b>		<b>Yes No DK</b>	
Artificial (prosthetic) heart valve.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous infective endocarditis.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged valves in transplanted heart.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease (CHD)					
Unrepaired, cyanotic CHD.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired (completely) in last 6 months.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired CHD with residual defects.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</i>					
<b>Yes No DK</b>		<b>Yes No DK</b>		<b>Yes No DK</b>	
Cardiovascular disease.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other congenital heart defects.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic heart disease.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusion.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, date: _____					
Hemophilia.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV infection.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disease.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid arthritis.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Systemic lupus erythematosus.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus trouble.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Chemotherapy/ Radiation Treatment.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain upon exertion.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic pain.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Type I or II.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorder.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Malnutrition.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal disease.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G.E. Reflux/persistent heartburn.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis, jaundice or liver disease.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells or seizures.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological disorders.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify: _____					
Sleep disorder.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you snore?.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health disorders.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify: _____					
Recurrent Infections.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type of infection: _____					
Kidney problems.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persistent swollen glands in neck.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe headaches/ migraines.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe or rapid weight loss.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexually transmitted disease.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive urination.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?.....

Name of physician or dentist making recommendation: \_\_\_\_\_ Phone: *Include area code* ( )

Do you have any disease, condition, or problem not listed above that you think I should know about?.....

Please explain: \_\_\_\_\_

**NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Dentist: \_\_\_\_\_ Date: \_\_\_\_\_

Comments: \_\_\_\_\_

**FOR COMPLETION BY DENTIST**

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