

PATIENT INFORMATION (CONFIDENTIAL)

NAME FIRST MI LAST DATE STATE/PROV. ZIP/P.C. ADDRESS CITY HOME PHONE E-MAIL CELL PHONE SS#/SIN BIRTHDATE CHECK APPROPRIATE BOX: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL CITY STATE/PROV. PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER WORK PHONE BUSINESS ADDRESS CITY STATE/PROV. ZIP/P.C. SPOUSE OR PARENT'S/GUARDIAN'S NAME EMPLOYER WORK PHONE WHOM MAY WE THANK FOR REFERRING YOU? PERSON TO CONTACT IN CASE OF AN EMERGENCY PHONE

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT RELATIONSHIP TO PATIENT ADDRESS HOME PHONE DRIVER'S LICENSE # BIRTHDATE SS#/SIN EMPLOYER WORK PHONE IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES NO

INSURANCE INFORMATION

NAME OF INSURED RELATIONSHIP TO PATIENT BIRTHDATE SS#/SIN DATE EMPLOYED NAME OF EMPLOYER UNION OR LOCAL # WORK PHONE EMPLOYER ADDRESS CITY STATE/PROV. ZIP/P.C. INSURANCE CO. TEL. # GRP # POLICY / I.D. # INS. CO. ADDRESS CITY STATE/PROV. ZIP/P.C. HOW MUCH IS YOUR DEDUCTIBLE? HOW MUCH HAVE YOU USED? MAX ANNUAL BENEFIT?

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED RELATIONSHIP TO PATIENT BIRTHDATE SS#/SIN DATE EMPLOYED NAME OF EMPLOYER UNION OR LOCAL # WORK PHONE EMPLOYER ADDRESS CITY STATE/PROV. ZIP/P.C. INSURANCE CO. TEL. # GRP # POLICY / I.D. # INS. CO. ADDRESS CITY STATE/PROV. ZIP/P.C. HOW MUCH IS YOUR DEDUCTIBLE? HOW MUCH HAVE YOU USED? MAX ANNUAL BENEFIT?

ITEM 07-0515767/27000

X SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR PATIENT NUMBER

REGISTRATION

PATIENT'S DENTAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

REASON FOR THIS VISIT _____
WHEN WAS YOUR LAST DENTAL VISIT _____ WHAT WAS DONE THEN _____
HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN _____
PREVIOUS DENTIST (NAME AND LOCATION) _____
HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN WHEN/WHERE _____
HOW OFTEN DO YOU BRUSH YOUR TEETH _____ HOW OFTEN DO YOU FLOSS YOUR TEETH _____
IS YOUR DRINKING WATER FLUORIDATED _____

	YES	NO		YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS	<input type="checkbox"/>	<input type="checkbox"/>	DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU FEEL PAIN TO ANY OF YOUR TEETH	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS)	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH	<input type="checkbox"/>	<input type="checkbox"/>	EVER WORN A BITE PLATE OR OTHER APPLIANCE	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?			HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS	<input type="checkbox"/>	<input type="checkbox"/>
CLICKING	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU WEAR DENTURES OR PARTIALS	<input type="checkbox"/>	<input type="checkbox"/>
PAIN (JOINT, EAR, SIDE OF FACE)	<input type="checkbox"/>	<input type="checkbox"/>	IF YES, DATE OF PLACEMENT _____		
DIFFICULTY IN OPENING OR CLOSING	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS	<input type="checkbox"/>	<input type="checkbox"/>
DIFFICULTY IN CHEWING	<input type="checkbox"/>	<input type="checkbox"/>			
DO YOU HAVE FREQUENT HEADACHES	<input type="checkbox"/>	<input type="checkbox"/>			
DO YOU CLENCH OR GRIND YOUR TEETH	<input type="checkbox"/>	<input type="checkbox"/>			

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? _____

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY

INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X _____ DATE _____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

DOCTOR'S COMMENTS _____

SIGNATURE _____ DATE _____

PATIENT'S NUMBER _____

PATIENT'S MEDICAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	YES	NO		YES	NO
1. ARE YOU IN GOOD HEALTH.	<input type="checkbox"/>	<input type="checkbox"/>	12. HAVE YOU EVER TAKEN FEN-PHEN/REDUX	<input type="checkbox"/>	<input type="checkbox"/>
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR	<input type="checkbox"/>	<input type="checkbox"/>	13. HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL OR ANY CANCER MEDICATIONS CONTAINING BISPHOSPHONATES?	<input type="checkbox"/>	<input type="checkbox"/>
3. DATE OF YOUR LAST PHYSICAL EXAM: _____			14. HAVE YOU TAKEN VIAGRA, REVATIO, CIALIS OR LAVITRA IN THE LAST 24 HOURS?.	<input type="checkbox"/>	<input type="checkbox"/>
4. PHYSICIAN'S NAME _____ ADDRESS _____ PHONE NO. _____			15. DO YOU USE TOBACCO	<input type="checkbox"/>	<input type="checkbox"/>
5. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN	<input type="checkbox"/>	<input type="checkbox"/>	16. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES	<input type="checkbox"/>	<input type="checkbox"/>
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS PLEASE EXPLAIN. _____			17. ARE YOU WEARING CONTACT LENSES	<input type="checkbox"/>	<input type="checkbox"/>
7. ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE	<input type="checkbox"/>	<input type="checkbox"/>	18. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)	<input type="checkbox"/>	<input type="checkbox"/>
IF YES, WHAT MEDICINE(S) ARE YOU TAKING _____			19. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT	<input type="checkbox"/>	<input type="checkbox"/>
8. HAVE YOU HAD ANY ABNORMAL BLEEDING.	<input type="checkbox"/>	<input type="checkbox"/>	WOMEN ONLY:		
9. DO YOU BRUISE EASILY.	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT	<input type="checkbox"/>	<input type="checkbox"/>
10. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU NURSING	<input type="checkbox"/>	<input type="checkbox"/>
11. HAVE YOU HAD A RECENT WEIGHT LOSS.	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU TAKING BIRTH CONTROL PILLS	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO		YES	NO
ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:			HIVES OR SKIN RASH.	<input type="checkbox"/>	<input type="checkbox"/>
LOCAL ANESTHETICS LIKE NOVOCAINE.	<input type="checkbox"/>	<input type="checkbox"/>	FAINTING OR DIZZY SPELLS.	<input type="checkbox"/>	<input type="checkbox"/>
PENICILLIN OR OTHER ANTIBIOTICS	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>
SULFA DRUGS.	<input type="checkbox"/>	<input type="checkbox"/>	AIDS OR HIV INFECTION	<input type="checkbox"/>	<input type="checkbox"/>
BARBITURATES, SEDATIVES OR SLEEPING PILLS	<input type="checkbox"/>	<input type="checkbox"/>	THYROID PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
ASPIRIN	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>	<input type="checkbox"/>
IODINE.	<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS OR RHEUMATISM	<input type="checkbox"/>	<input type="checkbox"/>
ANY METALS (E.G., NICKEL, MERCURY, ETC.).	<input type="checkbox"/>	<input type="checkbox"/>	JOINT REPLACEMENT OR IMPLANT	<input type="checkbox"/>	<input type="checkbox"/>
LATEX / RUBBER	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH ULCER	<input type="checkbox"/>	<input type="checkbox"/>
OTHER (PLEASE LIST) _____			KIDNEY TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:			TUBERCULOSIS.	<input type="checkbox"/>	<input type="checkbox"/>
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>	PERSISTENT COUGH	<input type="checkbox"/>	<input type="checkbox"/>
SCARLET FEVER.	<input type="checkbox"/>	<input type="checkbox"/>	COUGH THAT PRODUCES BLOOD	<input type="checkbox"/>	<input type="checkbox"/>
HEART DEFECT OR HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	CHEMOTHERAPY (CANCER, LEUKEMIA).	<input type="checkbox"/>	<input type="checkbox"/>
HEART TROUBLE, HEART ATTACK, OR ANGINA	<input type="checkbox"/>	<input type="checkbox"/>	SEXUALLY TRANSMITTED DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
CHEST PAIN	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY OR SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>
SHORTNESS OF BREATH.	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>
PACEMAKER	<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>
HEART SURGERY	<input type="checkbox"/>	<input type="checkbox"/>	NERVOUSNESS	<input type="checkbox"/>	<input type="checkbox"/>
HIGH/LOW BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	TONSILLITIS	<input type="checkbox"/>	<input type="checkbox"/>
CONGENITAL HEART PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>	TUMORS.	<input type="checkbox"/>	<input type="checkbox"/>
SWELLING OF FEET, ANKLES, HANDS.	<input type="checkbox"/>	<input type="checkbox"/>	MENTAL HEALTH CARE	<input type="checkbox"/>	<input type="checkbox"/>
HEPATITIS, JAUNDICE OR LIVER DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	BACK PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
STROKE	<input type="checkbox"/>	<input type="checkbox"/>	CHEMICAL DEPENDENCY.	<input type="checkbox"/>	<input type="checkbox"/>
SINUS TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	MITRAL VALVE PROLAPSE	<input type="checkbox"/>	<input type="checkbox"/>
LUNG OR BREATHING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	CORTISONE TREATMENT	<input type="checkbox"/>	<input type="checkbox"/>
ASTHMA OR HAY FEVER	<input type="checkbox"/>	<input type="checkbox"/>	COLD SORES/FEVER BLISTERS	<input type="checkbox"/>	<input type="checkbox"/>
			HYPOGLYCEMIA	<input type="checkbox"/>	<input type="checkbox"/>
			EATING DISORDERS.	<input type="checkbox"/>	<input type="checkbox"/>

ITEM 27011

PATIENT'S NUMBER _____

Welcome to our Practice!

You chose us over all others, so our promise to you is to provide you with the best dental care possible, in a warm and service-oriented environment. Thanks for this opportunity!

Please understand how we try and handle the following issues:

Insurance Issues and Payment

Your insurance is a contract between you, your employer, and an outside source. We respect this, and will help you achieve your benefit by filing your insurance for you.

We will do our best to estimate your portion; however, any remaining balance after receiving insurance benefits is your responsibility. You are responsible, in case of default, for any and all collection and/or reasonable attorney fees.

Signature _____

Financial Arrangements

We offer a wide arrangement of options for you to afford your care, and will actively work with you in choosing which option suits you best.

1. **Courtesy discounts** for major restorative work.
2. **No interest (6-12 months), low monthly payments** that fit your budget (CareCredit).
3. We accept all major credit cards, debit cards and checks.

Signature _____

Office Hours and Emergencies

We are open Monday-Wednesday 8:00am until 5:00pm, and Thursday 7:00am until 3:00pm by appointment. Emergency service is available to established patients on weekends.

Cancellations / Re-Schedules

In the unfortunate event that you should need to cancel your dental appointment we do ask that you notify us 24 hours in advance. There is limited time to adequately see all patients in need, and we feel of best service to our practice when we can accommodate as many as possible as soon as possible. Therefore, if no notice is given when an appointment is missed, we ask that you be responsible for a "courtesy cancellation fee" which will go towards patients which were declined treatment due to your reserved appointment. Should you miss two appointments without notice, we would no longer feel comfortable in a patient-practice relationship, and would happily transfer your records to another practice.

Signature _____

Authorization for Release of Information

Name of Patient _____ Date of Birth _____

William Blaine Rudisill, DMD. is authorized to release protected health information about the above named patient to the entities names below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	Description of information to be released. Check each that can be given to person/entity on the left in the same section.
<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Results of lab tests/x-rays
<input type="checkbox"/> Email	<input type="checkbox"/> Other
<input type="checkbox"/> Spouse	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: <u>treatment plan</u>
<input type="checkbox"/> Parent (provide name) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: <u>treatment plan</u>
<input type="checkbox"/> Other (provide name) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: <u>treatment plan</u>

PATIENT INFORMATION

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

Date _____

Signature of Patient or Personal Representative _____
Description of Personal Representative's Authority (attach necessary documentation)