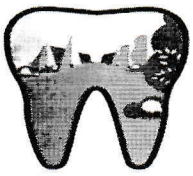

GREEN ROAD DENTAL

Patient Information (Confidential)

Name: _____

Address: _____ Postal Code: _____

City: _____ Preferred Method of contact: Home Cell Email

Res Phone: _____ Cell # _____

Email: _____ Date of Birth D _____ M _____ Y_____

How did you hear about our office? _____

Householder Information (where you would like correspondence sent)

Name of Parent/Guardian: _____ Phone Number _____

Address: (if different then above) _____

_____

Insurance Information

Name of Primary Insurance Holder _____

Insurance Company _____ Birthday of Insured D ____ M ____ Y_____

Policy/Group # _____ Certificate ID # _____

Do you have secondary insurance? YES NO

Name of Secondary Insurance Holder _____

Insurance Company _____ Birthday of Insured D ____ M____ Y_____

Policy/ Group # _____ Certificate ID # _____

Phone # _____

Please Procced to the Medical and Dental Health Portion found on next page →

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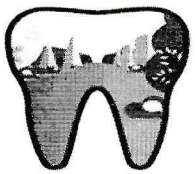

GREEN ROAD DENTAL

Medical History

The following information is required for legal reasons, and is strictly confidential. All facts are needed for the correct diagnosis and safe treatment. Please answer by circling YES or NO.

Name of Physician: _____ Phone #: _____

1. Are you currently seeing a physician for an ongoing aliments? If yes please specify _____	**YES**	**NO**
2. Are you currently taking any prescription medication? Please list them _____	**YES**	**NO**
3. Have you had an unusual reaction to any prescription medications? Please list _____	**YES**	**NO**
4. Have you ever been given cortisone or steroids?	**YES**	**NO**
5. Do you have any allergies (hay, fever, latex)?	**YES**	**NO**
6. Do you have any sinus problems?	**YES**	**NO**
7. Do you bleed or bruise easily?	**YES**	**NO**
8. Do you have a pacemaker or Mitro Valve Prolapse?	**YES**	**NO**
9. Do you have a heart disease or heart murmur?	**YES**	**NO**
10. Are you pregnant?	**YES**	**NO**
11. Did you have any artificial joint surgery?	**YES**	**NO**
12. Do you smoke	**YES**	**NO**

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

Anemia	Chronic Lung Disease	High Blood Pressure	Rheumatic Fever
Asthma	Diabetes	Kidney Troubles	Stroke
Blood Disorders	Epilepsy	Leukemia	Thyroid Trouble
Cancer	Heart Attack	Liver Trouble	Tuberculosis
Chemotherapy	Heart Trouble	Radiation	Venereal Disease
Eating Disorder (anorexia, bulimia etc.)	Psychiatric Disorders or Treatment	Aids/HIV	

14. Do you have any other conditions or concerns that you need to let us know?

_____

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GREEN ROAD DENTAL

Dental History

1. Does food catch between your teeth? **YES** **NO**
2. Do you gums bleed when brushing or eating? **YES** **NO**
3. Have you ever experienced any of the following jaw problems?
   - Popping or clicking in your jaw joint?
   - Pain in your jaw joints, around your ear or on the side of your face?
   - Difficulty in opening or closing?
   - Pain when teeth are clenched?
   - Pain or difficulty when chewing?
4. Are you happy with the appearance of your teeth? **YES** **NO**
5. Have you ever had an upsetting or traumatic experience in a dental office, or any complications during a dental treatment? **YES** **NO**

   Please specify _____
6. Do you have any specific requests that will make your visit more pleasant? **YES** **NO**
7. What was the date of your last dental visit? _____
8. What was the date of your last dental cleaning? _____
9. What was the date of your last complete set of x-rays? _____
10. What was your main reason for your visit today?

    _____

    _____
11. Any conditions or concerns of which your dentist should be aware of? Please specify

    _____

I authorize release, to my insurance company/plan administrator, the information contained in the claims submitted whether electronically or by mail. I authorize study models, photographs and or x-rays to be taken and used for the purpose of my personal treatment. I understand the responsibility for payment of dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services. I also understand that an appointment made is a contract and I understand that missed appointments may be an additional charge, if they become a habit. I agree that Green Road Dental can collect, use and disclose personal information about me set out in the Personal Health Information Protection Act (PHIPA). This is to certify that I, the undersigned, understand the above information is mandatory for my proper and safe care and the information is correct and compete to the best of my knowledge. I hereby give permission to my third part to verify and expand on information given.

Signature of Patient _____ Date _____

Signature of Doctor _____ Date _____

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