MEDICAL HISTORY

Patient's Name _____
Last First Initial Date of Birth

Circle the appropriate answer. If you don't know the correct answer, please write don't know beside the question.

1. Physician's Name _____
   Address _____
   _____ Phone _____
2. Are you under a physician's care? . . . . . Yes No
   Since when? _____ Why? _____
3. When was your last complete physical exam? _____
4. Are you taking any medication or substances? . . . . . Yes No
   (If yes, please list medications on back of this form in box provided)
5. Do you routinely take health-related substances? . . . . . Yes No
6. Are you allergic to any medications? . . . . . Yes No
7. Do you have any other allergies? . . . . . Yes No
8. Do you have any problems with antibiotics, anesthetics or other medications? . . . . . Yes No
9. Are you sensitive to any metals or latex? . . . . . Yes No
10. Women: Are you pregnant or suspect you might be? . . . . . Yes No
11. Women: Do you use birth control medication? . . . . . Yes No
12. Have you ever been treated or been told you have heart disease? . . . . Yes No
13. Do you have a pacemaker or an artificial heart valve? . . . . . Yes No
14. Have you been told you need antibiotics prior to dental work?……...Yes No
15. Have ever you been told you have a heart murmur (such as Mitral Valve Prolapse)? . . . . . Yes No
16. Do you have high or low blood pressure? . . . . . Yes No
17. Have you ever had a serious illness or major surgery? . . . . . Yes No
    If yes, please explain. _____
18. Have you ever had radiation treatment or chemotherapy for a tumor growth, or other condition? . . . . . Yes No
19. Do you have inflammatory diseases like arthritis or rheumatism ? . . . Yes No
20. Do you have any artificial joints/prosthesis? . . . . . Yes No
21. Do you have any blood disorders? (anemia, leukemia, etc.) . . . . . Yes No
22. Have you ever bled excessively after being cut or injured? . . . . . Yes No
23. Do you have any stomach problems? . . . . . Yes No
24. Do you have any kidney problems? . . . . . Yes No
25. Do you have any liver problems? . . . . . Yes No
26. Are you a diabetic? . . . . . Yes No
27. Do you have asthma? . . . . . Yes No
28. Do you have epilepsy or seizure disorders? . . . . . Yes No
29. Do you or have you had any venereal disease? . . . . . Yes No
30 Have you ever tested **POSITIVE** for HIV?. . . . . Yes No
31. Do you have AIDS? . . . . . Yes No
32. Have you had or do you test positive for hepatitis? . . . . . Yes No
33. Do you or have you had TB? . . . . . Yes No
34. Do you smoke, chew, use snuff or any other forms of tobacco? . . . . Yes No
35. Do you consume alcoholic beverages? . . . . . Yes No
36. Do you habitually use controlled substances? . . . . . Yes No
37. Have you ever had psychiatric treatment? . . . . . Yes No
38. Do you have any disease, condition or problem not listed? . . . . . Yes No
    If so, explain _____
39. Is there anything else we should know about your health that we have not covered in this form? _____
40. Would you like to speak to Dr. Hanson privately about any problem? Yes No

I certify that the above information is complete and accurate. If there are any changes in my health status in the future, I will inform Dr. Hanson or his staff. I have also been given access to the Patient Privacy Notice and my rights therein.

Patient's/Guardian's Sig. _____ Date _____

DENTAL ACQUAINTANCE FORM

Please answer the questions by circling the answer that best fits your response. (If you are uncertain about the question, leave it unanswered.)

1. Do you frequently experience canker sores or cold sores? . . . . . Yes No

2. Do you have lumps or sores in your mouth now? . . . . . Yes No

3. Have you ever been treated for gum/periodontal disease? . . . . . Yes No

   If yes, how was your problem treated _____

4. Does hot, cold, pressure or sweets cause discomfort in your mouth? . . . . . Yes No

5. Do you:
   a) clench your teeth . . . . . Yes No
   b) grind your teeth . . . . . Yes No
   c) breathe through your mouth . . . . . Yes No
   d) smoke or use other tobacco products . . . . . Yes No

6. Have your ever had:
   a) orthodontic treatment(braces) Yes No
   b) extractions . . . . . Yes No
   c) root canal treatment . . . . . Yes No
   d) TMJ treatment . . . . . Yes No
   e) jaw surgery . . . . . Yes No
   f) dental implants . . . . . Yes No
   g) periodontal treatment . . . . . Yes No

7. Are you nervous about dental treatment? . . . . . Yes No

8. Have you ever had trouble with dental treatment in the past? (i.e.; dizziness, fainting, etc.) . . . . . Yes No

   If yes, please explain _____

9. Have you ever had an unpleasant experience in the dental office? . . . . . Yes No

   If yes, please explain _____

10. What are your primary dental concerns now? _____

11. My mouth is . . . _____ very comfortable _____ moderately comfortable _____ uncomfortable

12. I am _____ very satisfied _____ somewhat satisfied _____ unsatisfied with the appearance of my mouth.

13. I think my present state of dental health is . . . _____ excellent _____ good _____ poor.

14. Please share any other questions or concerns about your dental health that you would like to discuss. _____

COMMENTS

CRAIG M. HANSON, D.D.S., P.C.
ADULT REGISTRATION FORM

Name:_____Date:_____

How do you wish to be addressed?_____ Date of Birth_____

Address_____ City_____

State_____ Zip Code_____

Home #_____Work #_____Cell #_____

E-mail address_____

Occupation_____ Employer_____

Social Security #_____ Business #_____

Dental Insurance Co._____ Group #_____

Name of Spouse_____ Date of Birth_____

Occupation_____ Employer_____

Social Security #_____ Business #_____

Dental Insurance Co._____ Group #_____

How will payment be handled? Cash Check Credit Card

Name of person not living with you to notify in case of an emergency:

Relationship _____ Phone _____

How did you hear about our office? (Please give name if appropriate)

_____

CRAIG M. HANSON, D.D.S. P.C.
CHILD REGISTRATION FORM

Child's Name_____Date of Birth_____

Address_____City_____

State_____ Zip Code _____

Home Phone_____Cell Phone_____

Father's Name_____ Date of Birth_____

Employer_____ Bus. Phone _____

Occupation_____S.S.# _____

Father's Dental Insurance Co._____ Group #_____

Father's Address (if different than child's)_____

City_____State_____Zip_____

Mother's Name_____Date of Birth_____

Employer_____Bus. Phone_____

Occupation_____S.S.# _____

Mother's Dental Insurance Co._____ Group #_____

Mother's Address (if different than child's)_____

City_____State_____Zip_____

Who will be responsible for this account?_____

How will payment be handled? Cash Check Credit Card

Name of person not living with you to notify in case of emergency_____

Relationship_____Phone _____

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How did you first hear about our office (please give name if appropriate)_____

Are you aware of any dental problems your child is having?_____If yes, please specify_____

How long since your child's last dental visit? _____Last X-rays?_____

Any previous negative dental experiences?_____If yes, please explain_____

APPOINTMENT CANCELLATION POLICY

To Our Patients:

When you schedule an appointment with us, we do not double book. We reserve our staff and our facility time exclusively for you to allow us to complete your needed treatment. The time interval for most dental procedures is one hour or more. A failed appointment without sufficient notice does not allow us to offer the time to another patient in need and adds to the time our patients have to wait before they can be seen. These failed appointments add to the cost of dentistry.

We require at least twenty-four hours notice prior to cancellation of a scheduled appointment so that we may offer that appointment to another patient. We realize that on occasion, it may not be possible to give twenty-four hours notice, however those instances should be rare. For Monday appointments, we request that you cancel by the prior Thursday since our office is closed on most Fridays and weekends.

We will attempt one courtesy call to remind you of your appointment at the telephone number that you designate. Should that number change, please let us know. We usually call in the morning on the day prior to your appointment. For Monday appointments or for days following holidays, we call on the last day prior to your appointment that we are scheduled to be in the office. If you are not available when we call, we will leave a message, but we cannot be responsible for the delivery of that message. It is ultimately your responsibility to keep your appointment.

We try to respect your time with a punctual appointment schedule and by informing you if there will be a delay in our schedule. Now that you are aware of our policy, we hope you will appreciate and respect our time. It is only with great reluctance that we charge a fee of $75.00 for missed appointments.

By signing below, I acknowledge that I have read and understand the above stated appointment cancellation policy.

Signature_____ Date _____

IMPORTANT INFORMATION FOR OUR PATIENTS

We are honored to have you as a patient, and we will do our very best to provide you with the best dental care available in the most pleasant manner possible.

It is our experience that many difficulties can be avoided if all the parties involved are informed about what is expected. Prior to undertaking any dental treatment, you will be informed of why the treatment is necessary, the various options to treat your particular dental problem, and potential problems with any proposed treatment. You will be provided a chance to ask any questions you have about the proposed treatment.

We also feel it is important that you understand our office policies. Payment is expected at the time services are rendered. We accept personal checks, cash, Visa, Mastercard and American Express. Any checks returned for non-sufficient funds will be subject to a $25.00 service charge.

For those patients who have dental insurance coverage, we are happy to bill your insurance company for you. However, to provide this service, we must have complete insurance information and confirmation of your coverage. Please inform us of any changes that occur in your insurance coverage.

After confirmation of your insurance coverage, you will be expected to meet your deductibles and pay those portions not covered by your insurance at the time services are rendered. After claims are settled with your insurance company, any remaining balances must be paid within thirty days of settlement of those claims.

This is a courtesy that we extend to our patients. If a problem should arise, we will be happy to provide your insurance company with any additional information necessary. We expect all balances to be cleared in less than sixty days. In certain instances, we will extend a payment plan on large cases. These plans should be arranged prior to the initiation of treatment. All accounts receivable over ninety days will be sent to collection unless the guarantor of the account has made arrangements prior to that time. A service fee of $25.00 will be added to any account that is sent to our collection service.

Finally, when we schedule appointment time for your care, our staff and chair time are reserved exclusively for you. As a courtesy, we confirm all appointments by telephone at least twenty-four hours in advance, but the ultimate responsibility for that appointment time is yours. We realize that on rare occasions, that may not be possible. However our general policy states that for failed appointments or those canceled with less than twenty-four hours notice, a cancellation fee may be charged to your account.

Signature_____Date _____