

Patient Registration and Health History

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

Mark R. Driver, D.M.D., P.C.

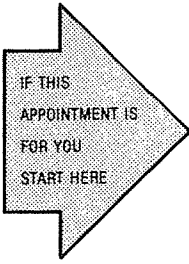
Benjamin Driver, D.M.D.

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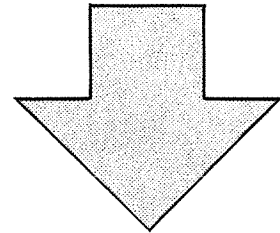
(541) 672-8187



DATE	EMAIL:			1
NAME				
SPOUSE				
ADDRESS				
CITY/STATE/ZIP				
HOME PHONE No.		CELL PHONE NO.		
BIRTHDATE		AGE		
MARRIED	SINGLE	DIVORCED	WIDOWED	
SOCIAL SECURITY No.				
<hr/>				
DATE				
NAME				
ADDRESS				
CITY/STATE/ZIP				
HOME PHONE No.				
BIRTHDATE	AGE	GRADE		
SCHOOL				
IF YOUR CHILD'S NAME AND ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE ABOVE BOX ALSO.				



DENTAL INSURANCE		2
PRIMARY CARRIER		
INSURANCE COMPANY		
INSURANCE ADDRESS		
EMPLOYER		
EMPLOYEE	BIRTHDATE	
GROUP No.		
EMPLOYEE ID NO.		
SECONDARY CARRIER		
INSURANCE COMPANY		
INSURANCE ADDRESS		
EMPLOYER		
EMPLOYEE	BIRTHDATE	
GROUP No.		
EMPLOYEE ID NO.		



ACCOUNT INFORMATION		4
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
DRIVER'S LICENSE NO.		
BANK		
BRANCH		
YOUR:		
NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS	CITY	
BUSINESS TELEPHONE	EXT.	
YOUR SPOUSE'S:		
NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS	CITY	
BUSINESS TELEPHONE	EXT.	



GETTING TO KNOW YOU		3
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
THEIR NAME:		
REFERRED TO US BY		
YOUR FORMER ADDRESS		
CITY/STATE/ZIP		
PERSON TO CONTACT FOR EMERGENCY		
PHONE NUMBER		
ADDRESS		
CITY/STATE/ZIP		
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NUMBER		
ADDRESS		
CITY/STATE/ZIP		

HEALTH HISTORY

CIRCLE

- 1. Are you having pain or discomfort at this time? YES NO
- 2. Do you feel very nervous about having dental treatment? YES NO
- 3. Have you ever had a bad experience in the dental office? YES NO
- 4. Have you been a patient in the hospital during the past two years? YES NO
- 5. Have you been under the care of a medical doctor during the past two years? YES NO

Physician's Name _____

Address _____ Phone # _____

- 6. Have you ever taken or are you scheduled to be taking any oral or IV form of bisphosphonate medications including alendronate (Fosamax®) or risedronate (Actonel®) YES NO

If yes, please explain: _____

- 7. Are you now taking any medication, drugs or pills? YES NO

If yes, please list all non-prescription & prescription medications: _____

- 8. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? YES NO

If yes, please list: _____

What is the reaction? _____

- 9. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure	YES	NO	Emphysema	YES	NO	Abnormal Bleeding	YES	NO
Heart Disease or Attack	YES	NO	Cough	YES	NO	Blood Transfusion	YES	NO
Angina Pectoris	YES	NO	Tuberculosis (TB)	YES	NO	Drug Addiction	YES	NO
High Blood Pressure	YES	NO	Asthma	YES	NO	Chronic Pain	YES	NO
Heart Murmur	YES	NO	Sinus Trouble	YES	NO	Sexually Transmitted Disease		
Mitral Valve Prolapse	YES	NO	Allergies or Hives	YES	NO	(Syphilis, Gonorrhea)	YES	NO
Rheumatic Fever	YES	NO	Diabetes	YES	NO	Cold Sores	YES	NO
Congenital Heart Defect	YES	NO	Thyroid Disease	YES	NO	Sleep Disorder	YES	NO
Rheumatic Fever	YES	NO	Alcohol Dependency	YES	NO	Fainting or Dizzy Spells	YES	NO
Artificial Heart Valve	YES	NO	Tobacco Use	YES	NO	Epilepsy or Seizures	YES	NO
Heart Pacemaker	YES	NO	Cancer/Chemotherapy/Radiation	YES	NO	Mental Health Disorder	YES	NO
Heart Surgery	YES	NO	Arthritis	YES	NO	Nervousness	YES	NO
Artificial Joints (Hip, Knee)	YES	NO	Autoimmune Disorder	YES	NO	Eating Disorder	YES	NO
Anemia	YES	NO	Steroid Therapy	YES	NO	Osteoporosis	YES	NO
Stroke	YES	NO	Glaucoma	YES	NO	GE Reflux	YES	NO
Kidney Trouble	YES	NO	Pain in Jaw Joints	YES	NO	Gastrointestinal Disease	YES	NO
Ulcers	YES	NO	A.I.D.S. or H.I.V.	YES	NO	Severe or Rapid Weight Loss	YES	NO
Cosmetic Surgery	YES	NO	Hepatitis or Liver Disease	YES	NO			

- 10. Do you have any disease, condition, or problem not listed? YES NO

Specify: _____

FOR WOMEN ONLY:

Are you pregnant? Yes No If yes, due date: _____. Are you taking birth control pills? Yes No

Comments: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature: _____ Date ____ / ____ / ____

CONSENT:

The undersigned hereby authorizes Driver Dentistry and its staff to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Driver Dentistry to make a thorough diagnosis of the patient's dental needs. I also authorize Driver Dentistry to perform any and all forms of agreed upon treatment, including referrals and records sent to specialist, medication and therapy, that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Service provided in this office for myself or dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1½% finance charge (18% annually) will be added to any balance over 60 days. In the event of default (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient _____ Date ____ / ____ / ____

Parent or Responsible Party _____ Relationship to Patient _____