PATIENT'S NAME_____ NAME CALLED_____
First Middle Last

IF CHILD: PARENT'S NAME_____
First Middle Last

HOME ADDRESS_____
Street City State Zip

HOME PHONE (_____)_____-_____ OFFICE PHONE (_____)_____-_____

EMAIL ADDRESS _____CELL PHONE ( )_____-_____

DATE OF BIRTH _____/_____/_____ SOC. SEC. NO. _____-_____-_____

MARITAL STATUS _____ MALE / FEMALE

EMPLOYER _____ OCCUPATION_____

BUSINESS ADDRESS_____
Street City State Zip

SPOUSE_____ PATIENT HERE? yes no
First Middle Last

SPOUSE'S EMPLOYER _____PHONE (_____)_____-_____

EMERGENCY CONTACT:_____PHONE (_____)_____-_____

WHO MAY WE THANK FOR REFERRING YOU?_____

MAY WE SEND THEM A THANK YOU CARD FOR REFERRING YOU? YES NO

DENTAL INSURANCE:

Ins. Company _____
Address: _____
Phone No: _____
Group Name: _____
Group Number: _____
Policyholder: _____
Date of birth: _____
Soc. Sec. No. : _____

I acknowledge that the above information is true, to the best of my knowledge. I authorize the release of any information regarding my past, present or future health care, that may influence my dental care, to and from Dr. Davenport and/or his representatives. I authorize Dr. Davenport and/or his representatives to contact my insurance carrier regarding my insurance coverage and the filing of claims. I have received and read this office's policy on payment for services rendered ("Financial Policy") understand it fully. I understand that I am fully responsible for all charges incurred during treatment, regardless of insurance coverage.

SIGNATURE_____ DATE_____
(Parent or Guardian, if patient is under 18 years old)

REGISTRATION

MEDICAL HISTORY

Circle

1. Have you ever been seriously ill? YES NO
2. Have you ever been hospitalized? YES NO
3. Have you been examined by a physician within the last year? YES NO
   Physician's name _____ Phone _____
4. Have you taken any drugs or medications in the last year? YES NO
5. Are you allergic to any medications or substances? YES NO
6. Check any of the following that you have or have had:

[ ] Heart problems	[ ] Emphysema	[ ] A.I.D.S or HIV positive
[ ] High blood pressure	[ ] Tuberculosis (TB)	[ ] Hepatitis A (infectious)
[ ] Heart murmur	[ ] Asthma	[ ] Hepatitis B (serum)
[ ] Chest pains (Angina)	[ ] Sinus trouble	[ ] Hepatitis C
[ ] Rheumatic fever	[ ] Allergies or Hives	[ ] Liver disease
[ ] Artificial joints	[ ] Diabetes	[ ] Bruise easily
[ ] Anemia	[ ] Thyroid disease	[ ] Drug addiction
[ ] Stroke	[ ] Venereal disease	[ ] Hemophilia
[ ] Kidney trouble	[ ] Chemotherapy	[ ] X-ray or cobalt therapy
[ ] Ulcers	[ ] Arthritis	[ ] Cold sores
[ ] Epilepsy	[ ] Seizures	[ ] Pain in jaw joints
[ ] Fainting	[ ] Dizzy spells	[ ] Psychiatric treatment

7. Are you aware of any weight change in recent months? YES NO
8. Do you find yourself short of breath after mild exertion? YES NO
9. Do you have frequent or severe headaches? YES NO
10. Are you subject to frequent urination? YES NO
11. Are you often thirsty? YES NO
12. Do you smoke? YES NO
13. Are you aware of any medical condition not mentioned above? YES NO

FOR WOMEN ONLY:

Are you pregnant? [ ] YES [ ] NO If yes, what month? _____

Are you taking birth control pills? YES NO

DENTAL HISTORY

1. Who was your former dentist? Name_____ City _____
2. Frequency of care: [ ] Semiannual [ ] Annual [ ] Irregular [ ] Emergency only
3. How would describe your present dental health? [ ] GOOD [ ] FAIR [ ] POOR
4. How often do you brush your teeth? _____
5. How often do you floss your teeth? _____
6. Are you having pain or discomfort at this time? YES NO
7. Do you have discomfort with the jaw joints? YES NO
8. Do you experience neck aches, tender jaw muscles, or limited oral opening? YES NO
9. Do you grind your teeth? YES NO
10. Do your gums bleed when you brush? YES NO
11. Check any of the following specialists you have seen:
    [ ] Periodontist (gums) [ ] Orthodontist [ ] Endodontist (root canal)
12. How do you feel about losing your teeth?
    [ ] Never, if possible [ ] No feeling [ ] You're suppose to [ ] Better without them

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE AND COMPLETE.

SIGNATURE _____ DATE _____

MED / DENT HISTORY

Name ___________________________

DATE	MEDICATION	REASON TAKING MEDICATION	DOSAGE

MEDICATIONS