

REGISTRATION & HEALTH UPDATE

NAME _____ AGE _____ TODAY'S DATE _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ E-MAIL ADDRESS _____

CURRENT EMPLOYER _____ WORK PHONE _____

NAME OF PHYSICIAN _____ CITY _____

PLEASE CIRCLE ANY CONDITIONS / TREATMENT IN THE FOLLOWING:

HEART PACEMAKER ARTIFICIAL JOINT HIGH BLOOD PRESSURE LIVER DIABETES
HEADACHES CANCER BLEEDING KIDNEYS LUNGS SKIN PSYCHIATRY
BRAIN/ NERVOUS SYSTEM IMMUNE SYSTEM (HIV or AIDS) STOMACH / GI ALLERGIES

Please describe items circled and dates: _____

I AM ALLERGIC TO: _____

PLEASE LIST CURRENT PILLS / MEDICATIONS: _____

I AM CONCERNED ABOUT: COLD SORES CANKER SORES TEETH GRINDING BAD BREATH
TEETH WHITENING LUMPS or BUMPS in / on HEAD / NECK OTHER _____

AS YOU KNOW, PEOPLE WHO USE TOBACCO PRODUCTS OR DRINK ALCOHOL REGULARLY ARE AT INCREASED RISK OF ORAL CANCER...

NUMBER OF YEARS SMOKED _____ PACKS / DAY _____ REGULAR ALCOHOL USE? Y N

I FLOSS ONCE EVERY _____ I WATER PIK ONCE EVERY _____

FINANCIAL POLICIES

I understand that payment is expected the day services are rendered, unless other arrangements are made in advance. I further understand that, regardless of any insurance, any balance left on an account past 30 days is subject to a billing charge of \$5, or a finance charge of 1.39% per month, (18% expressed as an Annual Percentage Rate), whichever is greater. There is a \$25 charge for checks returned from your bank. If we refer the collection of your account to an attorney, you agree to pay our reasonable attorney's fees, court costs or other collection costs as permitted by law.

(This is the same payment policy that has been in effect for over 12 years, so nothing has changed)

Signed _____ Date _____