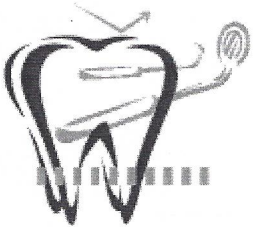

KEVIN BONE, D.D.S.

WELCOME TO OUR PRACTICE

Today's Date: _____

Please take your time to fill out this form completely. The more we learn about you, the better care we are able to provide. We look forward to working with you to maintain a healthy, happy smile.

Patient Information

First Name_____ Middle Initial_____ Last Name_____
Preferred Name (nickname, etc.)_____ Male_____ Female_____
Address_____ City_____ State_____ Zip_____
Home Phone (____) _____-_____ Work (____) _____-_____ Cell (_____) _____
Date of Birth _____ Social Security Number _____
Email _____
Employer _____ Occupation _____
Spouse's Name _____ Spouse's Employer _____
Whom May We Thank For Referring You? _____
If patient is a minor, name of parent or legal guardian and relationship_____

Dental Insurance Information

Primary Carrier		Secondary Carrier	
Insurance Co. Name	_____	Insurance Co. Name	_____
Group Number	_____	Group Number	_____
ID Number	_____	ID Number	_____
Insured's Name	_____	Insured's Name	_____
Insured's DOB	_____	Insured's DOB	_____
Employer	_____	Employer	_____

Person to Contact in case of Emergency

Name _____ Relationship _____
Home Phone (_____) _____-_____ Cell (_____) _____-_____

Payment is due in full at the time of treatment

I understand that I am responsible for payment of service rendered and any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency that may release such information to you.

Signature _____ Date_____

Dental History

Level of anxiety about seeing the dentist: (least) 1 2 3 4 5 (most)
Previous dentist's name _____ Phone Number (___) _____-_____
May we ask why you are changing dentists and the reason? _____
Do you require antibiotics before dental treatment? _____yes _____no

Medical History

Indicate which of the following you have had or have at present:

AIDS/HIV	YES NO	Difficulty Breathing	YES NO	Lupus	YES NO
Alcohol Addiction	YES NO	Emphysema	YES NO	Asthma	YES NO
Mitral Valve Prolapse	YES NO	Drug Addiction	YES NO	Glaucoma	YES NO
Epilepsy/Seizures	YES NO	Allergies or Hives	YES NO	Anxiety	YES NO
Fainting/Dizzy Spells	YES NO	Neurological Disorders	YES NO	Anemia	YES NO
Frequent Headaches	YES NO	Radiation Therapy	YES NO	Hay Fever	YES NO
Arthritis/Rheumatism	YES NO	Artificial Heart Valve	YES NO	Joint Replace	YES NO
Heart (Surgery/disease/attack)	YES NO	Scarlet Fever	YES NO	Blood Disease	YES NO
Rheumatic Fever	YES NO	Heart Pacemaker	YES NO	Colitis	YES NO
Shingles/Chicken Pox	YES NO	Heart Murmur	YES NO	Diabetes	YES NO
Sickle Cell Disease	YES NO	Blood Transfusion	YES NO	Jaundice	YES NO
Cancer/Chemo	YES NO	Bruise Easily	YES NO	Tumors	YES NO
Abnormal Bleeding	YES NO	Sinus Trouble	YES NO	Stroke	YES NO
Snoring/Sleep Apnea	YES NO	Thyroid Problems	YES NO	Chest Pain	YES NO
Hepatitis-A, B, C (circle)	YES NO	Cold Sores/Herpes	YES NO	Tuberculosis	YES NO
Stomach Problems	YES NO	Kidney Trouble	YES NO	Ulcers	YES NO
High Blood Pressure	YES NO	Low Blood Pressure	YES NO	Liver Disease	YES NO
Eating Disorder	YES NO	Venereal Disease/STD	YES NO	Angina	YES NO
Pacemaker	YES NO	Night Sweats	YES NO	Dry Mouth	YES NO

Test for HIV or AIDS N/A Poss Neg Test for TB N/A Poss Neg
Surgery: Please list with year YES NO _____
Cancer: Please list with year YES NO _____
Have you ever taken any Bisphosphonates; such as Fosomax? YES NO
Please list any serious medical condition(s) that you have ever had not listed above: _____
Are you aware of having an allergic (or adverse) reaction to any of the following?

Aspirin	YES NO	Iodine	YES NO	Codeine	YES NO
Metals	YES NO	Sulfa Drugs	YES NO	Anesthetics	YES NO
Latex	YES NO	Penicillin	YES NO	Other Antibiotics	YES NO

Have you been hospitalized or under the care of a medical doctor during the past 2 years? ____yes ____no
If yes, for what? _____
Physicians name _____ Phone Number (___) _____-_____
Are you currently taking any medications or drugs? _____yes _____no
If yes, please list: _____
_____
Women only: Are you pregnant or think you may be pregnant? _____yes _____no
Are you nursing: _____yes _____no? Are you taking birth control? _____yes _____no

Patient Signature _____
All information is protected by Doctor-Patient Confidentiality. You will be held responsible if statements are untrue.