

REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____
 SS# _____
 Patient Name _____
 Address _____
 City _____ State _____ Zip _____
 How Long? _____
 E-mail _____
 Sex M F Age _____
 Birth Date _____
 Parent's Name _____
 Parent's Employer _____
 Favorite Toy/Item _____
 Favorite Sport _____
 Favorite Person _____
 Favorite Book _____
 Whom may we thank for referring you? _____

Acknowledgement of Receipt of Notice of Privacy Policies
 I, _____, have received a copy of Dr. Robert J. Sex-
 auer, Notice of Privacy Policies. I understand Dr. Robert J. Sex-
 auer may use my health care information and may disclose such
 information for treatment, payment, and health care operations.

_____ Printed Name
 _____ Signature & Date

2 FINANCIAL INFORMATION

Who is financially responsible for this account?

 Relationship to Patient _____
 Insurance Co. _____
 Group# _____
 Is patient covered by additional insurance? Yes No
 Subscriber's Name _____
 Birth Date _____ SS# _____
 Relationship to Patient _____
 Insurance Co. _____
 Group # _____

Insurance Assignment

I certify that I, and/or my dependents(s), have insurance coverage

with _____ and assign directly to
Name of insurance company(ies)

Dr. _____
 all insurance benefits, if any, otherwise payable to me for services rendered.

Financial and Personal Health Information

I understand that I am financially responsible for all charges incurred dur-
 ing treatment. I further understand that any insurance contract is between
 my insurance carrier and myself. Dr. Robert J. Sexauer is not part of
 that contract. As a courtesy to our valued patients we will submit your
 insurance forms initially. If problems occur with insurance portion of your
 obligation, the balance in full will become due in 30 days. We will provide
 information to help you deal with your carrier. I understand that finance
 charges will begin 60 days from date of service if the balance is not paid
 in full. I authorize the use of my signature on all insurance submissions.

 Signature of Patient, Parent, Guardian or Personal Representative

 Please print name of Patient, Parent, Guardian or Personal Representative

 Date

 Relationship to Patient

3 PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext _____ Cell Phone (_____) _____
 Parent's Work (_____) _____ Best time and place to reach you _____
 IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)
 Name _____ Relationship _____
 Home Phone (_____) _____ Work Phone (_____) _____

4 HEALTH HISTORY UPDATE

To be updated at your future dental visits

Date Of Visit	Changes To Health History / Medication	Detail Changes Initials
1. _____	YES _____ NO _____	_____
2. _____	YES _____ NO _____	_____
3. _____	YES _____ NO _____	_____

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DENTAL HISTORY

Reason for today's visit _____
 Former Dentist _____
 City/State _____
 Date of last dental visit _____
 Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Are you satisfied with the appearance of your teeth? Yes No
 Bad Breath Yes No
 Bleeding Gums Yes No
 Blisters on lips or mouth Yes No
 Burning sensation on tongue Yes No
 Chew on one side of mouth Yes No
 Cigarette, pipe, or cigar smoking Yes No
 Clicking or popping jaw Yes No
 Dry Mouth Yes No

Fingernail Biting Yes No
 Food collection between the teeth Yes No
 Grinding Teeth Yes No
 Gums swollen or tender Yes No
 Jaw pain or tiredness Yes No
 Lip or cheek biting Yes No
 Loose teeth or broken fillings Yes No
 Mouth Breathing Yes No
 Mouth pain, brushing Yes No
 Orthodontic Treatment Yes No
 Pain around ear Yes No
 Periodontal Treatment Yes No
 Sensitivity to cold Yes No
 Sensitivity to heat Yes No
 Sensitivity when biting Yes No
 Sore or growths in your mouth Yes No
 Would you like to keep your natural teeth? Yes No
 How often do you floss? _____
 How often do you brush? _____

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HEALTH HISTORY

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves <input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash <input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____ <input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery <input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands <input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions <input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck <input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments <input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer <input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, Persistent/Bloody <input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss (unexplained) <input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Radiation Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No	

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis: _____

Pharmacy Name _____

Phone (____) _____

ALLERGIES

Aspirin Local Anesthetic
 Barbiturates (Sleeping pills) Penicillin
 Codeine Sulfa
 Iodine Other _____
 Latex No Known Allergies