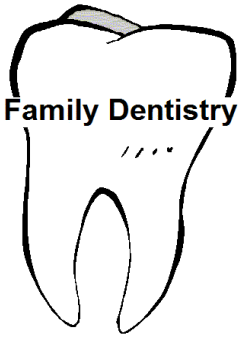

Kerry T. Plaisance, Jr., DDS
Maurice M. Bostick, DDS

W E L C O M E

Thank you for selecting our DENTAL TEAM! We will always offer you the most up to date care available. To help us meet your dental needs, please fill out these forms for us. Thank you for your assistance.

PATIENT INFORMATION

Today's Date_____

Name _____ S.S.# _____Birth Date _____
Wish to be called _____ □ Male □ Female □ Single □ Married
Address _____
City/State/Zip _____
Home Phone _____ Work Phone _____ Ext _____
Your Employer _____ Your Occupation _____
Insurance Company Name _____ Date of coverage_____
Name of spouse _____ Birth Date _____
Spouse employed by _____ S.S.#_____
Name of spouse's dental insurance company _____
Whom may we thank for referring you to our office? _____
Which Dr. do you wish to see (circle one) Dr. Plaisance Dr. Bostick

Name of person responsible for this account other than patient:
_____
Relationship to patient _____ Home Phone_____
Address _____
Email _____ Cell Phone _____
Is this person currently a patient of our office? □ YES □ NO

HOW CAN WE CONTACT YOU

Cellular Phone _____ Pager _____
Email _____
Where do you prefer to receive calls? □ Home □ Work □ Cellular □ Pager
When is the best time to reach you? Time _____ Days □ M □ T □ W □ T □ F
Please list name and phone number of someone who will know how to reach you in case of an emergency.
Name _____ Phone # _____

DENTAL CONCERNS

WHAT DID YOU NOT LIKE ABOUT YOUR PAST DENTAL APPOINTMENTS?

Was the treatment uncomfortable? □ YES □ NO
Was the staff unfriendly? □ YES □ NO
Were the fees not explained before your appointments? □ YES □ NO
Anything we have not thought of? _____

WHAT ARE YOUR FEELINGS ABOUT YOUR:

FRONT TEETH
Are you happy with their color? □ YES □ NO
Are you happy with their length? □ YES □ NO
Are they crowded or crooked? □ YES □ NO
Are you happy with their overall appearance? □ YES □ NO
Anything about them you would change? _____

BACK TEETH
Are they sensitive to hot or cold foods? □ YES □ NO
Do they trap food when you eat? □ YES □ NO
Anything about them you would change? _____

GUMS
Do they ever bleed? □ YES □ NO
Are they sensitive? □ YES □ NO
Have you ever seen a periodontist (gum specialist)? □ YES □ NO
If yes, whom? _____
Do you feel you have bad Breath? □ YES □ NO
Anything about them you would change? _____

MISSING TEETH
Do you have any missing teeth? □ YES □ NO
Are you wearing a replacement? □ YES □ NO
Is your replacement uncomfortable? □ YES □ NO
Anything about it you would change? _____
OVERALL: on a scale of 1→ 10, how would you rate the health of your teeth?
1 2 3 4 5 6 7 8 9 10

WHAT IS THE FIRST THING YOU WOULD LIKE US TO HELP YOU WITH?

_____

MEDICAL CONCERNS

We understand that you are here for us to help you care for your teeth and gums. Medications you are taking and health problems you may have could make a difference in how we treat your dental problems. This information is very important. Thank you in advance for you cooperation. Indicate which of the following you have had or have at the present.

HEART PROBLEMS	
Heart Disease / Attack	□ YES □ NO
Heart Failure	□ YES □ NO
Angina Pectoris	□ YES □ NO
Congenital Heart Disease	□ YES □ NO
Heart Murmur	□ YES □ NO
High Blood Pressure	□ YES □ NO
Arteriosclerosis	□ YES □ NO
Mitral Valve Prolapse	□ YES □ NO
Artificial Heart Valve	□ YES □ NO
Heart Pacemaker	□ YES □ NO
Heart Surgery	□ YES □ NO
Rheumatic Fever	□ YES □ NO
Stroke	□ YES □ NO
BLOOD PROBLEMS	
Blood Transfusion	□ YES □ NO
Hemophilia	□ YES □ NO
Anemia	□ YES □ NO
Sickle Cell Disease	□ YES □ NO
Bruise Easily	□ YES □ NO
GASTROINTESTINAL	
Ulcers	□ YES □ NO
Diabetes	□ YES □ NO
Thyroid Problems	□ YES □ NO
Liver Disease	□ YES □ NO
Yellow Jaundice	□ YES □ NO
Hepatitis A	□ YES □ NO
Hepatitis B	□ YES □ NO
Hepatitis C	□ YES □ NO

MUSCLES / BONES	
Arthritis	□ YES □ NO
Rheumatism	□ YES □ NO
Jaw Joint Pain	□ YES □ NO
Cortisone Medication	□ YES □ NO
Artificial Joints (hips, knee, etc)	□ YES □ NO
BREATHING PROBLEMS	
Emphysema	□ YES □ NO
Chronic Cough	□ YES □ NO
Tuberculosis	□ YES □ NO
Asthma	□ YES □ NO
Hay Fever	□ YES □ NO
Allergies or Hives	□ YES □ NO
Sinus Trouble	□ YES □ NO
Sleep Breathing Disorder	□ YES □ NO
GENERAL CONCERNS	
Kidney Trouble	□ YES □ NO
Venereal Disease	□ YES □ NO
A.I.D.S	□ YES □ NO
H.I.V. Positive	□ YES □ NO
Epilepsy or Seizures	□ YES □ NO
Fainting or Dizzy Spells	□ YES □ NO
Psychiatric Treatment	□ YES □ NO
Drug Dependence	□ YES □ NO
Radiation Therapy	□ YES □ NO
Chemotherapy	□ YES □ NO
Glaucoma or Eye Surgery	□ YES □ NO
Ever take Fen-Phen	□ YES □ NO
Tobacco Habit	□ YES □ NO

Are you under a Physician's care at this time □ YES □ NO
For what condition? _____ Physician's Name _____
Please list any medication you are now taking (including over the counter medications)

_____

Have you ever had an allergic reaction to anything? □ Penicillin □ Codeine □ Latex □ Other_____

FOR WOMEN ONLY

Are you pregnant? □ YES, what month _____ □ NO Are you nursing? □ YES □ NO
Are you taking birth control pills? □ YES □ NO

CONSENT

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.
The undersigned hereby authorizes, Dr. Bostick and/or Dr. Plaisance to take X-Rays, study models, photographs, or any other diagnostic aids deemed appropriate by, Dr. Bostick, and/or Dr. Plaisance to make a thorough diagnosis of the patient's dental needs. I also authorize, Dr. Bostick, and/or Dr. Plaisance to perform any and all forms of treatment, medication and therapy that may be indicated in connection with (name) _____ and further authorize and consent that, Dr. Bostick, and/or Dr. Plaisance choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand the reasonability of payment for Dental Services provided in this office for myself or my dependents are mine, due and payable at the time services are rendered unless financial arrangements have been made.

Patient _____Date _____