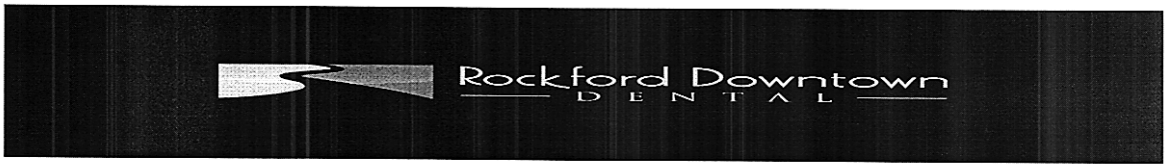

PATIENT INFORMATION

Last Name _____ First _____ Middle _____

What name would you like us to use? _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security No. _____ Email _____

Employer _____ City _____ State _____ Zip _____

Occupation _____ Fax _____

SPOUSE/RESPONSIBLE PARTY (if other than patient)

Name _____ Relationship to patient _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ City _____ State _____ Zip _____

EMERGENCY CONTACT: Name _____ Phone No. _____

DENTAL INSURANCE INFORMATION

Do you anticipate that your DENTAL INSURANCE will assist you with your account? Yes No

Insured's Name _____ Insured's Date of Birth _____

Insurance Co. _____ Insured's Soc. Sec. No. _____

Ins Co. Addresss _____ City _____ State _____ Zip _____

Insured's Employer _____ Group No. _____ Policy No. _____

Do you have double insurance coverage? Yes No

What is your reason for today's visit? _____

Is any other member of your family a patient in our practice? _____

How did you learn about our practice? ___ Friend (name) _____

___ Website ___ Yellow Pages ___ Ads ___ Newspaper Article ___ TV ___ Other _____

FINANCIAL POLICY

Full payment is expected at the time of each visit. For extensive cases, financial arrangements made in advance are available. Dental insurance is an agreement between you and the insurance company. Insurance only assists and does not relieve one of any financial obligations. Please note that a 1.5% interest charge will be added to balances that are 60 days past due. We will never allow the limitations of your benefits to compromise the quality of your care. Many of our patients participate in CareCredit, a special dental financing program. ___ Yes, please give me more information about this program option.

CONSENT: The undersigned hereby authorizes the dentist and his/her designated staff to take radiographs, study models, photographs, or any other diagnostic aids deemed necessary by the dentist to make a thorough diagnosis of the patient's dental needs. I also authorize the dentist and his/her designated staff to perform any and all forms of treatment, medication and therapy that may be indicated. All information on this page and the Medical History Form is correct and fully understood by me. I understand the financial policy and also assign all insurance benefits, if applicable, to the dentist.

Dr. Conlin occasionally uses photos of patients for teaching purposes. Please initial if you prefer your photos not be used for dental education. _____ Date _____

PATIENT SIGNATURE (Parent of Child) _____ **Date** _____

SMILE EVALUATION (circle Yes or No)

Name: _____

Date: _____

1. Do you like the way your teeth look? Yes No
   Explain: _____
2. Are you happy with the color of your teeth? Yes No
   Explain: _____
3. Would you like for your teeth to be whiter? Yes No
   Explain: _____
4. Would you like your teeth straighter? Yes No
   Explain: _____
5. Do you have spaces between your teeth that you would like closed? Yes No
   Explain: _____
6. Would you like your teeth to be longer? Yes No
   If so, Upper ____ Lower _____ Both ____ ?
7. Do you like the shape of your teeth? Yes No
   Explain: _____
8. Do you have missing teeth that you would like to replace? Yes No
   Explain: _____
9. Do you have old silver fillings that you would like to replace with tooth-colored fillings? Yes No
   Explain: _____
10. Have you ever had braces (ortho)? Yes No
    If yes, do you wear any type of retainer? Yes No
    Are you happy with the results? Yes No
11. If you could change anything about your smile, what would you change?

    _____

    _____

    _____

ROCKFORD DOWNTOWN DENTAL

Dr. CHAD CONLIN

PATIENT CONSENT FOR USE AND DISCLOSURE

OF PROTECTED HEALTH INFORMATION

Patient's Name: _____ Date: _____

I hereby give my consent for Dr. Conlin to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Dr. Conlin's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Conlin reserves the right to review the Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Conlin at 112 N. Monroe St., Rockford, MI 49341.

With this consent, Dr. Conlin may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carryng out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care.

With this consent, Dr. Conlin may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment cards and patient statements.

With this consent, Dr. Conlin may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. Conlin restrict how they use or disclose my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Dr. Conlin's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Dr. Conlin may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____

Print Name of Patient or Legal Guardian

I am also signing for my minor children: _____

I also give consent for my treatment to be discussed with the following individuals: (e.g. spouse, parent, adult child, caregiver)

_____

(please print names)

I also give my permission for information regarding ___ treatment ___ appointments ___ insurance benefits ___financial arrangements to be discussed with the above individuals. Date: _____

Time 2:50 PM

Rockford Downtown Dental

Date 4/5/2016

Rockford Downtown Dental Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics
☐ Clindamycin	☐ Other		

Do you use controlled substances?	Yes No	If yes	
Other?	☐	If yes	

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Anemia	Yes No	Cold Sores/Fever Blisters	Yes No	Cancer	Yes No
Hepatitis A	Yes No	Bleeding Disorder	Yes No	Anaphylaxis	Yes No	Chemotherapy	Yes No
Hepatitis B or C	Yes No	Blood Transfusion	Yes No	Sinus Trouble	Yes No	Radiation Treatments	Yes No
Yellow Jaundice/Liver Disease	Yes No	Blood Disease	Yes No	Asthma	Yes No	Immune Suppresant Therapy	Yes No
Artificial Heart Valve	Yes No	High/Low Blood Pressure	Yes No	Arthritis/Gout	Yes No	Leukemia	Yes No
Irregular Heartbeat	Yes No	High/Low Blood Sugar	Yes No	Rheumatism	Yes No	Stomach/Intestinal Disease	Yes No
Heart Murmur	Yes No	High Cholesterol	Yes No	Pain In Jaw Joint/TMD	Yes No	Thyroid/Parathyroid Disease	Yes No
Mitral Valve Prolapse	Yes No	Diabetes	Yes No	Artificial Joint	Yes No	Alzheimer's Disease	Yes No
Heart Pacemaker	Yes No	Bruise Easily	Yes No	Swelling of Limb	Yes No	Venereal Disease	Yes No
Heart Trouble/Disease	Yes No	Fainting Spells/Dizziness	Yes No	Osteoporosis	Yes No	Drug Addiction	Yes No
Heart Attck/Failure	Yes No	Frequent Headaches	Yes No	Hives or Rash	Yes No	Psychiatric Care	Yes No
Angina/Chest Pain	Yes No	Sleep Apnea	Yes No	Tuberculosis	Yes No	Kidney Problems	Yes No
Congenital Heart Disorder	Yes No	Breathing Problems/Lung Disease	Yes No	Glaucoma	Yes No	Spina Bifida	Yes No
Stroke	Yes No	Excessive Thirst	Yes No	Tonsillitis	Yes No	Epilepsy or Seizures	Yes No

Have you ever had any serious illness not listed Yes No If yes

Medication List:

Name and Dosage:

Additional Questions:

Are you unhappy with the appearance of your teeth?	○ Yes ○ No
Would you like whiter teeth?	○ Yes ○ No
Have you experienced any growths or sore spots in your mouth?	○ Yes ○ No
Do you have sleep or snoring issues?	○ Yes ○ No
Do your gums bleed?	○ Yes ○ No
Have you had periodontal or orthodontic care?	○ Yes ○ No
Do you clench or grind your teeth?	○ Yes ○ No
Do you have headaches/earaches or neck pain?	○ Yes ○ No
Are you apprehensive about dental treatment?	○ Yes ○ No
Is any part of your mouth sensitive to temperature or pressure?	○ Yes ○ No
Previous Dentist:	
Date of Last Visit:	
Family Physician:	
Phone Number:	

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____