

We are complimented that you have selected us to provide dental care for you and your family.

Patient Information

Date _____ Patients Name _____
Last First Middle
(If patient is a full time student fill in school name) _____
Address _____
Street City State Zip
Home Phone _____ Birthdate _____ Social Security # _____
If patient is a minor, give parent's or guardian's name _____
Whom may we thank for referring you to our office? _____
Name of nearest relative not living with you _____
Complete Address _____ Phone _____

Responsible Party Information

Name _____
Last First Middle Marital Status
Residence _____
Street City State Zip
Mailing Address _____
Street City State Zip
How long at this address _____ Home Phone _____ Work Phone _____
Previous Address (if less than 3 years) _____
Street City State Zip
Social Security # _____ Birthdate _____ Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed _____
Employer Address _____
Spouse's Name _____ Relationship to Patient _____
Last First Middle
Employer _____ Occupation _____ No. Years Employed _____
Employer Address _____
Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____
Insurance Company _____ Group No. _____
Insurance Co. Address _____ Ph. # _____
Is policy connected with your union? Yes _____ No _____ Name of Union _____ Local No. _____
Do you have dual coverage? Yes _____ No _____ If yes: **Please complete the following secondary insurance information.**
Insured's Name _____ Insured's Soc. Sec. # _____
Insurance Co. _____ Group No. _____ Local No. _____
Insurance Co. Address _____ Ph. # _____
Insured's Employer _____ Ph. # _____

Dental Information

Do your gums bleed when you brush? Yes _____ No _____ **Dentist** _____
Are your teeth sensitive to heat or cold? Yes _____ No _____ Pressure Yes _____ No _____ Sweets Yes _____ No _____
Do you grind or clench your teeth? Yes _____ No _____
Do you have any fear of dental work? Yes _____ No _____
Date of last dental examination _____ What was done at that time? _____
How would you describe your current dental problem? _____
How do you feel about the appearance of your teeth? _____

Medical Information

1. Are you having pain or discomfort at this time? YES NO
2. Have you been a patient in the hospital during the past two years? YES NO
3. Have you been under the care of a medical doctor during the past two years? YES NO
 Physician's Name _____ Phone No. _____
 Address _____
4. Have you taken any medication or drugs during the past two years? YES NO
5. Are you now taking any medication or drugs? YES NO
 If yes, please list: _____
6. Are you sensitive or allergic to any medication or anesthetics? YES NO
 If yes, please list: _____
7. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure YES NO	Artificial Joints (hip, knee, etc.) YES NO	Allergy to Latex YES NO
Heart Disease or Attack YES NO	Kidney Trouble YES NO	Hepatitis B (serum) YES NO
Angina Pectoris YES NO	Ulcers YES NO	Veneral Disease YES NO
Congenital Heart Disease YES NO	Diabetes YES NO	A.I.D.S. YES NO
Heart Murmur YES NO	Thyroid Problems YES NO	H.I.V. Positive YES NO
High Blood Pressure YES NO	Glaucoma YES NO	Cold Sores/Fever Blisters YES NO
Arteriosclerosis YES NO	Cancer YES NO	Blood Transfusion YES NO
Mitral Valve Prolapse YES NO	Emphysema YES NO	Hemophilia YES NO
Artificial Heart Valve YES NO	Chronic Cough YES NO	Anemia YES NO
Heart Pacemaker YES NO	Tuberculosis YES NO	Sickle Cell Disease YES NO
Heart Surgery YES NO	Asthma YES NO	Bruise Easily YES NO
Rheumatic Fever YES NO	Hay Fever YES NO	Liver Disease YES NO
Arthritis YES NO	Allergies or Hives YES NO	Yellow Jaundice YES NO
Rheumatism YES NO	Sinus Trouble YES NO	Epilepsy or Seizures YES NO
Cortisone Medicine YES NO	Radiation Therapy YES NO	Fainting or Dizzy Spells YES NO
Drug Addiction YES NO	Chemotherapy YES NO	Nervousness YES NO
Stroke YES NO	Hepatitis A (infectious) YES NO	Tumors YES NO
		Developmentally Disabled YES NO
8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? YES NO
9. Do your ankles swell during the day? YES NO
10. Do you use more than two pillows to sleep? YES NO
11. Have you lost or gained more than 10 pounds in the past year? YES NO
12. Do you ever wake up from sleep and feel short of breath? YES NO
13. Are you on a special diet? YES NO
14. Do you have or have you had any disease, condition, or problem not listed? YES NO
 If yes, please list: _____

FOR WOMEN ONLY:

Are you pregnant? Yes, what month? _____ No Are you nursing? Yes No Are you taking birth control pills? Yes No

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.

Patient Signature _____ Date _____

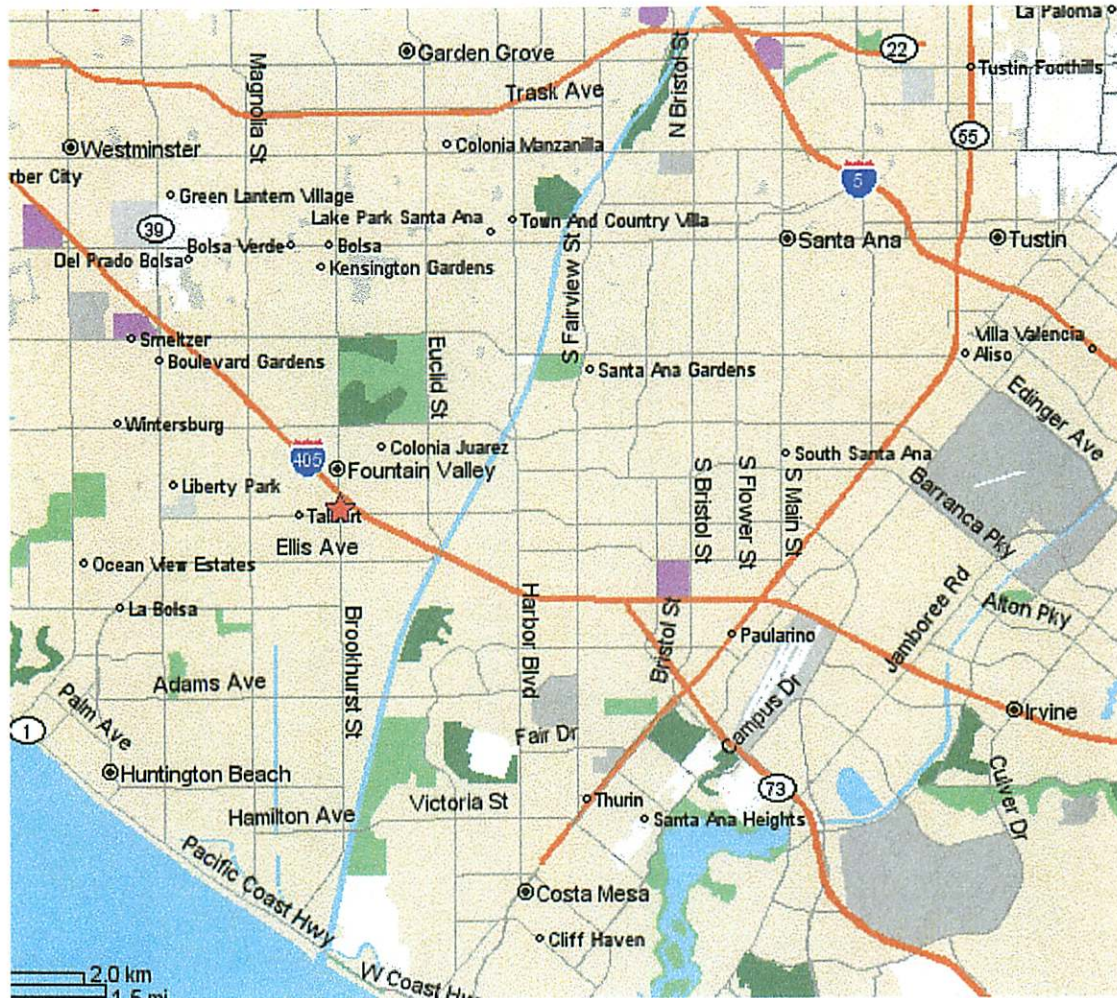
CONSENT:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 - 1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

Thomas P. Rose, D.D.S., M.S.D.
17900 Brookhurst St., Ste. C
Fountain Valley, CA 92708
(714)964-0021



DIRECTIONS:

From I-405 NORTH

Take I-405 North
Exit Brookhurst St. (South)
Move to far Left Lane
Make U-turn at Talbert (First Light)
Make Immediate Right into the driveway after Wendy's
Our Building is on the Left, next to the freeway

From I-405 SOUTH

Take I-405 South
Exit Brookhurst St. (South)
Immediately move over to far Left Lane
Make U-Turn at First Light which is Talbert
Make Immediate Right into the driveway after Wendy's
Our Building is on the Left, next to the freeway

From PCH (North or South)

Turn onto Brookhurst St.
Go past Talbert
Make an Immediate Right into the driveway after Wendy's
Our Building is on the Left, next to the freeway

From The 22 EAST

22 East
Exit Brookhurst St.
Turn Right onto Brookhurst St.
Go over 405 Freeway Bridge
Make U-Turn at Talbert (First Light)
Make Immediate Right into driveway after Wendy
Our Building is on the Left, next to the freeway

From The 22 WEST

22 West
Take Brookhurst Exit
Make Right onto Trask, stay in right lane
Make Right onto Brookhurst St.
Go over 405 freeway bridge
Make U-Turn at Talbert (First Light)
Make Immediate Right into driveway after Wendy
Our Building is on the Left, next to the freeway