Three Rivers Dental Group:

Date: _____/_____/_____

Name: _____Married Single Minor Male Female

Address: Street _____City _____ State_____Zip_____

IMPORTANT CONTACT INFORMATION: We may need to reach you about appointments, RX. & Instructions

Email Address:_____ We will <u>not</u> share your email or phone numbers.

Phone Numbers: Cell/Mobile _____ Home_____
Work_____

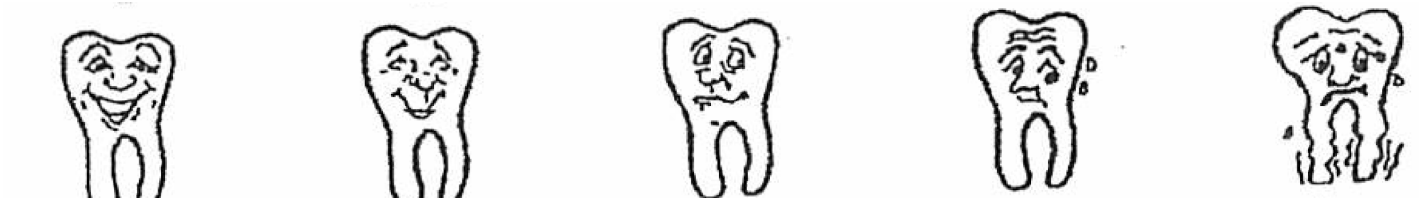
Alternate Phone numbers (wife/Husband) Cell/Mobile _____
_____

<u>If Insured do we have your Dental Insurance Information</u>? _____

Emergency Contact : Name _____Phone #_____

What is your dental priority? _____

Circle your level of Bravery: Don't Worry, We Cater to Cowards!



"Happy to see my Dentist"

Slightly Apprehensive

Mildly Apprehensive

Moderately Apprehensive

Very Apprehensive "Put Me To Sleep!"

Would you like to be put to sleep for your Dental Treatment? YES /NO

I realize a responsible adult (parent/Guardian) must remain in the office while treating a minor.
Three Rivers Dental engages its dentists as independent contractors, not employees. Dentists providing services as independent Contractors are insured and stand behind the high quality of their dental work. Our independent dentists make all clinical judgements and are solely responsible for the quality and appropriateness of any diagnosis, treatment, and outcome of dental services you receive at Three Rivers Dental.

Audio and Video Monitoring

Three Rivers Dental Group maintains audio and video monitoring of its offices for security, training and quality assurance. Three Rivers Dental Group consents to the monitoring of its employees and independent contractors in their interactions with one another and with you and requests your consent to this audio and video security monitoring.

By signing below, you agree that you fully understand and accept the foregoing arrangement to provide you dental services and the full consequences
of the same you consent to audio and video monitoring of your visits to all Three Rivers Dental Group offices, your consent will be continuous and
effective as to all future visits to Three Rivers Dental Group offices.

Patient Signature _____ Date _____

Health Information *All information is confidential*

Patient Name: _____DOB____/____/_____ Date of last Physical ____/____/____
Physician's name & phone #_____
Are you under the care of a physician? _____ Have you ever been hospitalized? _____
Are you taking or have taken any steroid/cortisone therapy in the last 2 years? _____
Are you taking or have taken Oral Bisphosphonates, e.g. FOSOMAX, ACTONEL, BONIVA, OR IV BISPHOS. e.g.,ZOMETA, AREDIA? _____ Taken for how long? _____
Have you pre-medicated with antibiotics prior to dental procedures in the past? _____
Have you had any adverse reaction or become ill to Penicillin, Aspirin, Codeine, Local Anesthetics, Latex, Metals, or any other medications? _____List any medications you are allergic to: 1. _____ 2. _____3. _____4. _____
List any medications you are currently taking including non-prescription drugs including herbals/vitamins 1. _____2. _____3. _____4. _____

Please <u>CHECK</u> Y or No for each category											
Any History of:	Y	N		Y	N		Y	N		Y	N
Rheumatic Fever			Depression			Thyroid Disease			Alcoholism		
Heart Murmur			Allergies or Hives			Epilepsy or Seizures			Psychiatric Treatment		
Mitral Valve Prolapse			Anemia			Fainting or DizzySpell			Mouth Sores/Growths		
Diabetes			Aspirin/Anticoagulant Therapy			Ulcers or Stomach Problems			Teeth Grinding/ clenching		
Pace Maker			Venereal Disease			Arthritis			Pain in Jaw (TMJ)		
High Blood Pressure			HIV Positive/AIDS			Latex Allergy			Any type of Implant		
Low Blood Pressure			Blood Transfusion			Sinus Problems			Any type of Transplant		
Heart Problems			Excessive Bleeding			Cancer (type)			Artificial Hip Joint		
Stroke			Hepatitis (type)			Chemotherapy			Artificial Knee Joint		
Lung Disease			Liver Disease			Radiation Treatment					
ADD/ADHD			Kidney Disease			Use of Tobacco					
Tuberculosis (TB)			Dialysis			Drug Addiction			Other Illness		

Women	Y	N		Y	N
Are you Pregnant?			Are you Nursing?		
Estimated Delivery Date: / /			Are you taking any birth Control Prescriptions?		

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge.

Patients Signature _____Date _____

Dr.'s Signature/Medical History Review _____ Date _____

We cannot share any information about your dental treatment including financials, insurance Etc. without your Authorization. Please provide name(s) of anyone we may share this information. Name_____ Relationship to patient_____

Please sign and date below acknowledging that our office has provided you with information regarding (HIPAA) The Health Insurance Portability & Accountability Act. A copy will be provided to you at your request.

Printed Name: _____

Patient Signature: _____ Date:_____