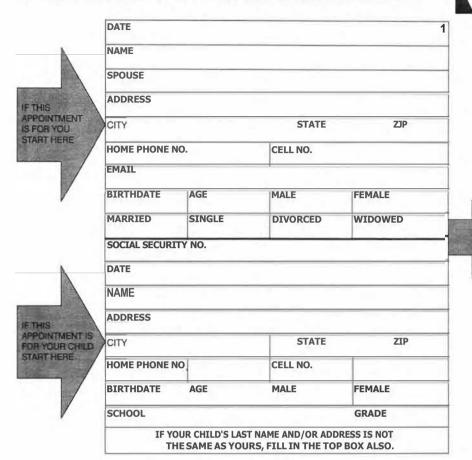
PATIENT REGISTRATION AND HEALTH HISTORY

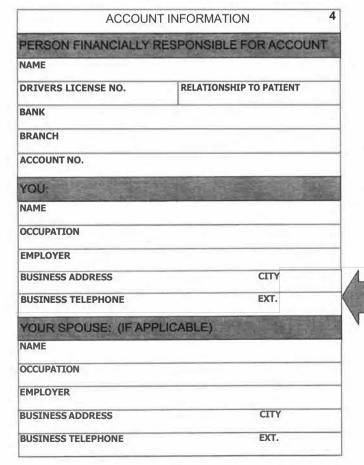
PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

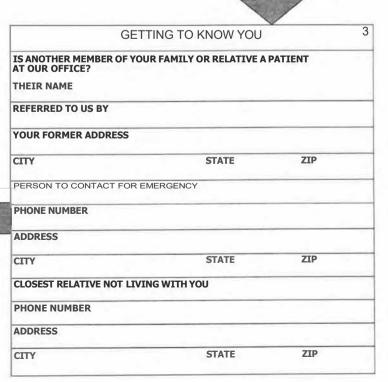




700 24th Avenue S.W. Norman, Oklahoma 73069 405-360-5566 Fax 405 360.3224 e-mail: blumdds @gmail.com

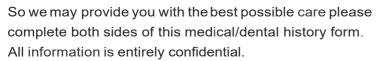
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INSUR	ANCE CO	PANY			
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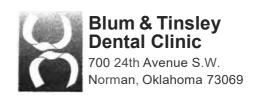




DENTAL HISTORY

Welcome to our office.





Date of last dental visitLa		Las	ast dental cleaning		Last full mouth x-rays			
What was	done at vour last den	tal visit′	?					
Your previous Dentist's nameS								
City				Z <u>ıp</u>	FIIONE			
How often do you see a dentist?			How often do you brush?		How often do you floss?			
Do you use	dental aids? (Toothpic	k, interp	olak, etc.)					
Do you have	e dental problems nov	/? Yes	□ No □	If yes, describe				
Are any of you	ur teeth sensitive to:				Have you ever had:			
	Hot or Cold?	Yes□	No□		Orthodontic treatment?	Yes□	No□	
	Sweets?	Yes D	No□		Oral surgery?	Yes□	No□	
	Biting or chewing?	Yes D	No0		Periodontal treatment?	Yes□	No□	
Have	you noticed any mouth			Your teeth	Your teeth ground or bite adjusted?		No□	
odors or bad tastes?		Yes□	No <u>□</u>	A bite plate or mouth guard?		Yes□	No□	
Do you frequently get cold sores, blisters or any other oral lesions?		Yes D	No 0	A serious injury to the head or mouth? Yes□ If yes-, describe, including the cause		No□		
Do your gums hurt or bleed?		Yes D	No 0					
Have yo	our parents experienced disease or tooth loss?	Yes D	No0	На	ave you experienced:			
	oticed any loose teeth or	Oliabian an n		g or popping of the jaw?	Yes D	No D		
Do	change In your bite? pes food become caught	Yes D	No □	Pain?	? (Joint, ear, side of face)	Yes□	No D	
f yes, where?	between your teeth?	Yes D	No□		ening/closing the mouth? ficulty chewing on either	Yes □	No0	
	Do you:				side of your mouth?	Yes□	No□	
Clench	or grind your teeth while			Head,	neck or shoulder aches?	Yes□	No□	
Cicilott	awake or asleep?	Yes D	No 0	Are y	ou satisfied with the wa your teeth look.	Yes□	No	
Bite your li	ps or cheeks regularly?	Yes D	No 0	Would yo	ou like to keep all of lour		-	
Hold (F	d object with your teeth? Pencils, pins, nails, etc.)	Yes□	No□	teeth all of your ife? Do you feel nervous about havln		Yes □	No	
Mouth Breathe	while asleep or awake?	Yes□	No□		dental treatment	Yes□	No 🗆	
Have	e tired jaws, especially in the morning?	Yes D	No □	If yes, what Is your biggest concern?				
	Smoke/chew tobacco?	Yes□	No0	Have yo	ou ever had an upsettln dental experience	Yes□	No 🗆	
Snore or gasp for air whlle sleeping, Wear a CPAP or been diagnosed with sleep Y		_p Yes□	No□	If yes, describe	<u> </u>			

MEDICAL HISTORY

Have you been under the care of a medical of	doctor during the past two years?	Yes O	No □						
If yes, for what reason?									
Physician's Name			Phone						
	City		State Zip						
	•	_	State 2ip						
Have you taken any medication or drugs du	ring the past two years? Yes	0 No□							
Are you currently taking any medications,	drugs, pills including medical marij	uana Yes	No						
If yes, list name dosage									
Are you aware of having an allergic or adver	se reaction to any medication or sub	stance?	Yes O No □						
Ifyes, describe									
Have you been a patient in the hospital durir									
	ig the past live years?								
Please indicate which of the following you ha	ve had, or have at present. Circle Y	for Yes, N	I for No.						
Heart Attack Common on Disease. V. N.	Ulcers	Y N	Hepatitis A (infectious) B (serum) Y N						
Heart Attack, Surgery or Disease Y N Chest Pain Y N	Diabetes		Vepereal Disease Y N						
	Thyroid Problems		. i = -						
Congenital Heart Disease	Glaucoma		A.I.D.S						
Heart Murmur Y N High Blood Pressure Y N	Contact Lenses		Cold Sores/Fever Blisters Y N						
Mitra! Valve Prolapse Y N	Emphysema		Blood Transfusion Y N						
Artificial Heart Valve Y N	Migraines		Hemophilia Y N						
Heart Pacemaker Y N	Autoimmune Disease		Sickle Cell Disease Y N						
Rheumatic Fever Y N	Asthma		Bruise Easily Y N						
Arthritis/Rheumatism Y N	Sleep Apnea		Liver Disease Y N						
Cortisone Medicine Y N	Latex Sensitivity		Yellow Jaundice Y N						
Swollen Ankles Y N	Allergies or Hives		Neurological Disorders Y N						
Stroke Y N	Sinus Trouble		Epilepsy or Seizures Y N						
Diet (Special/Restricted) Y N	Radiation Therapy	Y N	Fainting or Dizzy Spells Y N						
Artificial Joints (Hip, Knee, etc.) Y N	Chemotherapy		Nervous/Anxious Y N						
Kidney Trouble Y N	Tumors		Psychiatric/Psychological Care Y N						
Do you use more than two pillows to sleep	o? Yes D No □								
Here we have a major of many the set 40 mays	and in the mark war of								
Have you lost or gained more than 10 pou	nds in the past year? Yes D No) D							
Do you have or have you had any disease	e, condition, or problem not listed abo	ove? Yes	D No O						
If yes, describe									
Women: Are you pregnant? Yes D - Month	s No D Nursing? Yes I) No D	Taking birth control pills? Yes D No D						
			nt manner. I have answered all questions to the best of my by, who may release such Information to you. I will notify the						
Doctor of any change In my health or medication. The under	ersigned hereby authorlz.es Doctor to take x-ray,	study models, p	ohotographs, or any other diagnostic aids deemed appropriate of treatment, medica Uon and therapy, that may be Indicated						
In connection with thepatient. I further authorize and conse									
Patient Signature			Date						
Lastly, I understand that all responsibility for payment for de-	ental services provided In this office for myself o	r my dependent	s Is mine, due and payable at the time services are rendered						
unle.ss other arrangements have been made. In the avant pa account, I, understand treatment plans are an estimate of i			that a $1\cdot1/2$ o/e finance charge (18% APR) may be added to my nildren of Divorce are the parents.						
Patient	Date	Witness							