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Date: _____

Patient Last Name: _____ First Name: _____ Middle Initial: ____
Preferred Name to be called: _____
Address: _____
City: _____ State: ____ Zip: _____
email: _____
Sex: M F
Birth date: _____ Social: ____ - ____ - ____
Married Single Other
Patient Employer/School: _____

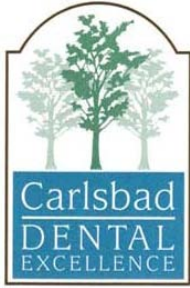
Spouses Name: _____
Birth date: _____
SS#: _____
Spouses Employer: _____

Who may we thank for referring you? _____

Phone Numbers: Home: _____ Work: _____ Cell: _____

In case of emergency contact:

Name: _____ Relationship: _____ Phone: (____) ____ - _____



Financial and Insurance Information:

Who is responsible for this account? _____ Relationship to patient: _____
Insurance Company: _____ Group Number: _____

Is patient covered by additional insurance? Yes No

Secondary Subscriber's Name: _____
Relationship to Patient: _____

Birth date: _____ SS# _____

Secondary Insurance Company: _____

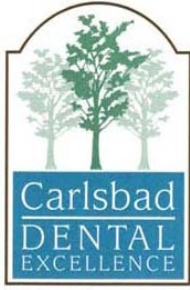
Assignment and Release:

I certify that I, and/or my dependents, have insurance coverage with _____ insurance company. I assign directly to Dr Manhard, dba Carlsbad Dental Excellence, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr Manhard or Carlsbad Dental Excellence may use my healthcare information and may disclose such information to the above named Insurance Companie(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

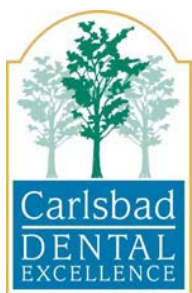
Signature of Patient, Parent, Guardian, or personal representative

Please print name of Patient, Parent, Guardian, or personal representative



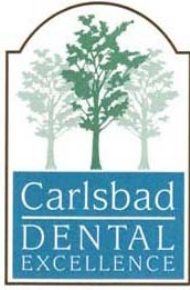
Dental History

Bad breath	Y	N	Cavity in last three years	Y	N
Bleeding gums	Y	N	Taking Fluoride at home	Y	N
Blisters on lips or mouth	Y	N		Y	N
Chew on one side of mouth	Y	N		Y	N
Cigarette, pipe, or cigar smoking	Y	N		Y	N
Clicking or popping jaw	Y	N		Y	N
Dry mouth	Y	N		Y	N
Fingernail biting	Y	N		Y	N
Food collection between teeth	Y	N		Y	N
Foreign objects	Y	N		Y	N
Grinding teeth	Y	N		Y	N
Gums swollen or tender	Y	N		Y	N
Jaw pain or tiredness	Y	N		Y	N
Lip or cheek biting	Y	N		Y	N
Loose teeth or broken fillings	Y	N		Y	N
Mouth breathing	Y	N		Y	N
Mouth pain, brushing	Y	N		Y	N
Orthodontic treatment	Y	N		Y	N
Pain around ear	Y	N		Y	N
Periodontal treatment	Y	N		Y	N
Sensitivity to cold	Y	N		Y	N
Sensitivity to heat	Y	N		Y	N
Sensitivity to sweets	Y	N		Y	N
Sensitivity when biting	Y	N		Y	N
Sores or growths in your mouth	y	N		Y	N



Medical History

AIDS/HIV	Y	N	Kidney disease	Y	N
Anemia	Y	N	Liver disease	Y	N
Arthritis, Rheumatoid	Y	N	Low blood pressure	Y	N
Artificial Heart valves	Y	N	Mitral valve prolapsed	Y	N
Artificial joints	Y	N	Nervous problems	Y	N
Asthma	Y	N	Pacemaker	Y	N
Back problems	Y	N	Psychiatric care	Y	N
Abnormal bleeding	Y	N	Radiation treatment	Y	N
Blood disease	Y	N	Respiratory disease	Y	N
Cancer	Y	N	Rheumatic fever	Y	N
Chemical dependency	Y	N	Scarlet fever	Y	N
Chemotherapy	Y	N	Shortness of breath	Y	N
Circulatory problems	Y	N	Sinus trouble	Y	N
Congenital heart lesions	Y	N	Skin rash	Y	N
Cortisone treatments	Y	N	Special diet	Y	N
Cough, persistent or bloody	Y	N	Stroke	Y	N
Diabetes	Y	N	Swollen feet or ankles	Y	N
Emphysema	Y	N	Swollen neck glands	Y	N
Epilepsy	Y	N	Thyroid problems	Y	N
Fainting or dizziness	Y	N	Tonsillitis	Y	N
Glaucoma	Y	N	Tuberculosis	Y	N
Headaches	Y	N	Head or neck tumor	Y	N
Heart murmur	Y	N	Ulcer	Y	N
Heart problems	Y	N	Venereal disease	Y	N
Hepatitis	Y	N	Weight loss	Y	N
Herpes	Y	N	Contact lenses	Y	N
High blood pressure	Y	N	Pregnant	Y	N
Jaundice	Y	N	Birth control pills	Y	N
Jaw pain	Y	N	Nursing	Y	N



Why are you here today?

What would you like us to specifically address?

Would you like to hear about financing options? yes no

Would you like to replace silver-mercury fillings yes no

We offer Sedation Dentistry for anxious patients. Are you interested? yes no

Would you like to discuss the appearance of your smile? yes no

Please rate the following on a scale of 1 to 10, (10 being highest) 1 2 3 4 5 6 7 8 9 10

How would you rate your present dental health? 1 2 3 4 5 6 7 8 9 10

Where would you like it to be? 1 2 3 4 5 6 7 8 9 10

How important is staying within your dental insurance annual plan maximum?

Not important Somewhat important Very important

What level of care do you think insurance pays for? 1 2 3 4 5 6 7 8 9 10

Are you looking for:

long term solutions or short term patchwork solutions?

Are there any concerns that would keep you from going forward with treatment yes no

If yes, list: _____

Thank you!