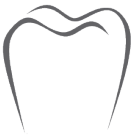
Welcome! *The benefits of a healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate, the better we care for you!*



GREGORY B. WRIGHT, DDS, PA
Metro (817) 481-7999

PATIENT REGISTRATION

NAME | I LIKE TO BE CALLED

SPOUSE/PARENT'S NAME IF CHILD | DATE

ADDRESS

CITY | STATE | ZIP | EMAIL

HOME PHONE | CELL PHONE | WORK PHONE

BIRTHDATE | AGE | GENDER M OR F | MARTIAL STATUS

SOCIAL SECURITY NUMBER | WHO MAY WE THANK FOR REFERRING YOU?

EMERGENCY CONTACT | CONTACT PHONE | RELATIONSHIP TO PATIENT

IS ANOTHER MEMBER OF YOUR FAMILY A PATIENT AT OUR OFFICE? Y OR N NAMES: | RELATIONSHIP TO PATIENT

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME

RELATIONSHIP TO PATIENT | SSN#

ADDRESS

CITY | STATE | ZIP

HOME PHONE | CELL

EMAIL

DENTAL INSURANCE

INSURANCE COMPANY

INSURANCE COMPANY PHONE

GROUP NO.

EMPLOYEE

DATE OF BIRTH | DATE EMPLOYED

YEARLY DEDUCTIBLE

EMPLOYEE SS#

ABOUT YOU

EMPLOYER | YRS EMPLOYED

OCCUPATION

BUSINESS ADDRESS

CITY | STATE | ZIP

BUSINESS PHONE

OTHER

ABOUT YOUR SPOUSE

EMPLOYER | YRS EMPLOYED

OCCUPATION

BUSINESS ADDRESS

CITY | STATE | ZIP

BUSINESS PHONE

OTHER

CONSENT

CONSENT FOR TREATMENT FOR _____
PLEASE PRINT PATIENT'S NAME

I attest that to the best of my knowledge the information provided is accurate and complete. Any changes in health status or medications will be reported to the Doctor at the next visit following the change. In addition I authorize the Doctor or his representative to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis and to develop proper treatment recommendations. I also authorize the Doctor to perform all forms of treatment, medication, and therapy that may be indicated, and further authorize and consent that the Doctor choose and employ such assistance as he deems fit. I understand that the use of anesthetic agents embodies a certain risk. I understand that 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 advance.

SIGNATURE | DATE

❑ PATIENT ❑ PARENT ❑ GUARDIAN

(TURN OVER TO COMPLETE)

MEDICAL HISTORY

General Health ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of Physician Phone No.

Have you been under medical care in the last 2 years? ☐ Yes ☐ No If Yes, Explain

Last complete physical Last blood pressure check Blood pressure

List all medications you take

Have you been treated for:

Acquired Immune Deficiency Syndrome (Aids)	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Abnormal Blood Pressure	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Congenital Heart Defects	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Murmur	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
What Type			Stroke	☐ Yes	☐ No
Radiation Treatment	☐ Yes	☐ No	Joint Replacement	☐ Yes	☐ No
Chronic Cough	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Osteoporosis Drugs	☐ Yes	☐ No
Dry Mouth (Xerostomia)	☐ Yes	☐ No	Sinus Troubles/Allergies	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Hepatitis or Jaundice	☐ Yes	☐ No	VD (syphilis, gonorrhea)	☐ Yes	☐ No

Are You Allergic To: ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Latex ☐ Other Medicines: List Others:

Are You Subject to Prolonged Bleeding	☐ Yes	☐ No	Fainting Spells or Dizzy Spells	☐ Yes	☐ No
Do You Have Any Condition Not Listed	☐ Yes	☐ No	If Yes, Explain		
(Women) Are You Pregnant	☐ Yes	☐ No	How Long?		
Taking Birth Control	☐ Yes	☐ No	Nursing	☐ Yes	☐ No

DENTAL HISTORY

Date of last dental visit Dentist's Name Phone No.

Did you have X-Rays taken ☐ Yes ☐ No Date of last dental cleaning

Do you wear full or partial dentures ☐ Yes ☐ No If Yes, how old are they

Have you had all of your teeth x-rayed in the past 3 years	☐ Yes	☐ No
Are you dissatisfied with the appearance of your teeth or smile	☐ Yes	☐ No
Would you change your smile if your could	☐ Yes	☐ No
Do you snore or have sleep apnea	☐ Yes	☐ No
Have you had orthodontic treatment	☐ Yes	☐ No
Do you clench or grind your teeth during the day or night	☐ Yes	☐ No
Have you ever had a pain in your jaw joint or your face or around your ear	☐ Yes	☐ No
Does your jaw joint click or pop	☐ Yes	☐ No
Do you have difficulty opening your mouth widely	☐ Yes	☐ No
Do you have an unpleasant odor, or taste in your mouth	☐ Yes	☐ No
Do your gums bleed when brushing	☐ Yes	☐ No
Have you ever been diagnosed with gum disease	☐ Yes	☐ No
Is your mouth or teeth sensitive to: Pressure ☐ Yes ☐ No Cold ☐ Yes ☐ No Hot	☐ Yes	☐ No
Does food catch between your teeth	☐ Yes	☐ No
Do you have difficulty getting numb for dental treatment	☐ Yes	☐ No

Please add anything you feel is important for the Doctor to know (Any special concerns)