

WELCOME TO OUR PRACTICE

On behalf of the entire team at our office, let us welcome you to our practice. We are grateful that you have chosen us to meet your dental needs, and trust that you will find your experience in our office to be pleasant, professional, and extraordinary. You may discover that we are different from the average dental practice. When you visit our office, you will find a unique and relaxing environment. Our team is friendly and attentive. All of our treatment is designed to be comfortable, to be long lasting, and to exceed all your expectations. We use the latest technology and techniques our profession has to offer. Our greatest strength lies in the unequaled advanced training in cosmetic and reconstructive dentistry we have received.

In order to better serve you, we are enclosing in this Welcome Packet several important documents that will assist us in making your transition to our office as smooth as possible. Please read each one carefully so that you can become familiar with our practice philosophy and policies. We are happy to answer questions you may have at any time.

Please find the enclosed Personal Information Sheet and Medical and Dental History questionnaire that should be filled out prior to your first appointment with us.

Be sure to visit our website at www.CoriCriderDDS.com. We look forward to serving all your dental needs for you and your family.

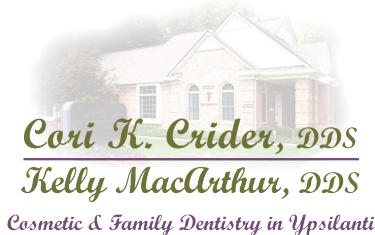
Yours truly for better dental health,

Cori K. Crider, DDS

Cori K. Crider, DDS

Kelly MacArthur, DDS

Kelly MacArthur, DDS



PATIENT REGISTRATION

Welcome to our office. Please be kind enough to answer the following questions. Thank you so much for being our guest!

	M F	S M D W			
Name (Last)	(First)	(Middle)	Date of Birth	Sex	Marital Status
How would you like to be addressed?			Email Address	Cell Phone Number	
Home Address (Street)	(City)	(State)	(ZIP Code)	Home Phone Number	
Name of Employer	Occupation			Driver's License Number	
Business Address (Street)	(City)	(State)	(ZIP Code)	Business Phone Number	

PERSON RESPONSIBLE FOR ACCOUNT

Who is responsible for account? self spouse parent/guardian other
 (Please fill in the following information if the person responsible is different from self.)

Name (Last)	(First)	(Middle)			Social Security Number
Home Address (Street)	(City)	(State)	(ZIP Code)	Home Phone Number	
Name of Employer	Occupation			Business Phone Number	

INSURANCE INFORMATION

Insured Member (Last)	(First)	(Middle)	Relationship	SSN	Date of Birth
Name of Employer	Occupation			Business Phone Number	
Business Address (Street)	(City)	(State)	(ZIP Code)	Dental Insurance Co.	
Group Number	ID Number				

What are your hobbies? Special interests? _____
 How did you hear of our office? _____

If patient was assisted with this form, enter name of person assisting:

Print name	Sign name	Date
Signature of patient		Date

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

General health (please check): EXCELLENT GOOD FAIR POOR Name of physician _____
Physician's Address _____ Telephone Number _____ Date of Last Physical _____

Are you now under the care of a physician? Yes No

Are you pregnant or do you think you may be pregnant? Yes No If yes, expected delivery date: _____

Are you nursing?.....Yes No

Are you taking birth control pills? Yes No

Do you smoke?Yes No If yes, how much? _____

Are you taking any medication now? Yes No If yes, names of medications and problems for which they are taken:

Medication 1) _____ Taken for _____ 3) _____ Taken For _____

2) _____ Taken for _____ 4) _____ Taken For _____

Do you use tobacco?.....Yes No

Have you ever taken Fen-Phen or Redux?.....Yes No

Have you ever required a blood transfusion?.....Yes No

Are you wearing contact lenses?.....Yes No

Do you or have you used controlled substances?.....Yes No

Do you bruise easily?.....Yes No

Have you ever had (please check-mark appropriate boxes):

Abnormal blood pressure..... High Low No

Heart surgery..... Yes No

AIDS/HIV..... Yes No

Hepatitis..... Yes No

Anemia..... Yes No

Jaundice..... Yes No

Arthritis..... Yes No

Joint replacement or implant..... Yes No

Asthma or hay fever..... Yes No

Kidney trouble..... Yes No

Allergies..... Yes No

Mental health care..... Yes No

Back problems..... Yes No

Lymph node enlargement (swollen glands)..... Yes No

Cancer..... Yes No

Mitral valve prolapse..... Yes No

Chemical dependency..... Yes No

Night sweats..... Yes No

Cold sores/Fever blisters..... Yes No

Pacemaker..... Yes No

Common cold..... Yes No

Persistent diarrhea..... Yes No

Congenital heart lesions..... Yes No

Prolonged bleeding..... Yes No

Diabetes..... Yes No

Rheumatic fever..... Yes No

Drastic weight loss..... Yes No

Sexually transmitted disease..... Yes No

Eating disorders..... Yes No

Sinus trouble..... Yes No

Epilepsy/Seizures..... Yes No

Swollen ankles..... Yes No

Excessive urination and/or thirst..... Yes No

Stroke..... Yes No

Fainting spells..... Yes No

Thyroid problem..... Yes No

Glaucoma..... Yes No

Tuberculosis or lung disease..... Yes No

Heart disease..... Yes No

Ulcers..... Yes No

Heart murmur..... Yes No

X-ray treatments for cancer..... Yes No

If you have entered "yes" to any of the above, please explain: _____

Are you allergic to or have you had reactions to:

Local anesthetics like Novocaine..... Yes No

Aspirin..... Yes No

Penicillin or other antibiotics..... Yes No

Iodine..... Yes No

Sulfa drugs..... Yes No

Any metal (e.g. gold, nickel, etc.)..... Yes No

Barbiturates, sedatives, or sleeping pills..... Yes No

Latex/Rubber..... Yes No

Codeine..... Yes No

Tylenol..... Yes No

Other (please list) _____

Have you had any other serious illness, hospitalization, or accident? _____

*Your signature indicates you have received a copy of the HIPAA law and Dental Materials forms and release Dr. Crider to utilize any dental photographs for lecturing and educational purposes.

Signature: _____ Date: _____

DENTAL HEALTH AND APPEARANCE

Reason for visit: _____ Approximate date of last dental visit: _____

What is your primary concern that you would like us to address first? _____

When would you like us to start treatment? _____

Have you ever had any serious problem associated with previous dental treatment or any dental emergencies?..... Yes No

If so, explain: _____

What, if anything, has happened in previous experiences at the dentist that was reason not to return? _____

Do you have missing teeth?_____ If yes, have you had them replaced?_____

If you have had missing teeth replaced, are you happy with the results? _____

If not, would you like to learn about your options to replace them? _____

Do you ever feel (or have you ever been told) that you don't have fresh breath? _____

How often do you brush your teeth?_____ How often do you floss? _____ What type of brush do you use? Manual Powered

Do you avoid brushing any part of your mouth because of pain? Yes No If yes, what part? _____

Which foods cause you twinges of pain: hot cold sweet sour none Do you lose fillings or break fillings?.....Yes No

Do you chew on only one side of your mouth?.....Yes No If yes, explain: _____

Do your gums feel tender or swollen?.....Yes No Do you usually have many cavities?.....Yes No

Do you clench or grind your jaws while sleeping or during the day?.....Yes No Do your jaws ever feel tired?.....Yes No

We respect your right to choose the level of care that fits *your* needs. We've found that many adults are unaware that problems even exist. There are rarely symptoms (pain, bleeding) associated with the aging and deterioration of teeth and gums – until it is far too late. According to the ADA, more than 80% of adult Americans have some level of gum disease. With your permission we would like to explain the choices available to achieve long-term health and beauty for your existing natural teeth. Please check all that apply:

- I desire to keep my own teeth for life, if possible. I want my teeth to look good, feel good, and last for a long time.
- Spreading payments out over time may help me to achieve the excellent results I desire.
- Phasing treatment, by priority, over a few years may make it feasible for me to achieve the excellent results I desire.
- I am interested in a plan for long-term dental health. However, I am currently unable to pursue this, and would appreciate help with emergencies and cleanings for now.
- Although I am not interested in a plan for long-term dental health, I do desire an office who will treat teeth in need of immediate/emergency attention, as well as keep me up to date on cleanings.

COSMETIC/ESTHETIC EVALUATION

Are you delighted with your smile? _____ Please rate your smile from 1 to 10 (1 = I hate my smile, 10 = awesome)_____

Would you like to have whiter teeth? Yes No

What (if any) personal or professional benefit might you gain if you had a gorgeous smile? _____

Do you have any special occasions coming up? _____

If you had a magic wand, what, if anything, would you change about your smile? Please check off all that apply:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Lighten all front teeth showing | <input type="checkbox"/> Rebuild fracture(s) | <input type="checkbox"/> Straighten rotation | <input type="checkbox"/> Eliminate dark or stained fillings |
| <input type="checkbox"/> Lighten single tooth | <input type="checkbox"/> Lengthen | <input type="checkbox"/> Straighten angulation | <input type="checkbox"/> Reduce gum showing in smile |
| <input type="checkbox"/> Close spaces between teeth | <input type="checkbox"/> Shorten | <input type="checkbox"/> Eliminate crowding | <input type="checkbox"/> Repair uneven edges |

Please add anything you feel is important: _____

At our office, though our focus is on appearance-related dentistry, our team also delivers routine general dental care. With flexible payment plans as well as phasing treatment over time, you and your family can achieve spectacular long-term results. Thank you so much for the opportunity to be of service.