

Dear Valued Patient,

Dr. Waddell and the whole staff welcome you to our dental practice.

When you come in, we ask that you bring the enclosed patient questionnaire. This will give us general information and your health history. We have to know about allergies, sensitivity to anesthetics, long-term medications and your whole health picture.

At your first visit, we will examine your teeth, gums, jaw alignment and soft tissues and perform an oral cancer screening. We will take the necessary x-rays to find areas of infection that need treatment, and take a series of digital photographs of your teeth to aid Dr. Waddell in diagnosing your condition.

You will also find enclosed an information sheet that includes a map to our office and general information about our dental philosophy.

Your mouth and teeth are an important part of your total physical health. We commend you on taking the first step toward healthy oral hygiene. We look forward to meeting you!

Sincerely,

Dr. Waddell and Staff

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: Policy Holder Preferred Name: _____
 Responsible Party

Responsible Party (if someone other than the patient) _____

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Social Security: _____ Driver's License: _____

Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

Email: _____ I would like to receive correspondences via email.

Section 2

Section 3

Employment Status: Full Time Part Time Retired

Employer: _____

Student Status: Full Time Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg: _____

Primary Insurance Information _____

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____

Ins. Company: _____

Address: _____

Address: _____

Address 2: _____

Address 2: _____

City, State, Zip: _____

City, State, Zip: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

Secondary Insurance Information _____

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____

Ins. Company: _____

Address: _____

Address: _____

Address 2: _____

Address 2: _____

City, State, Zip: _____

City, State, Zip: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

DENTAL HISTORY

Name: _____

Dental complaint at this time: _____

Last Dental Treatment on: _____ Last Cleaning on: _____

Do you: grind / clench your teeth? Yes No

 have jaw / joint pain? Yes No

 have sore/ sensitive teeth? Yes No

 have bleeding gums? Yes No

 have cold / canker sores? Yes No

 have unpleasant taste? Yes No

Are you happy with the way your teeth look? Yes No

Are you satisfied with the whiteness of your teeth? Yes No

Would you be interested in straightening your teeth without braces? Yes No

Are there any missing teeth that you would like to have replaced? Yes No

Do you have a fear of dentistry that keeps you from completing necessary dental procedures? Yes No

Is there anything about your smile that you would like to change: _____

How did you hear about our office?

_____ 1-800-DENTIST referral

_____ Metlife referral list

_____ Friend or family member (person's name _____)

_____ Received a "Welcome to the Neighborhood" post card

_____ Other: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Person: _____

Phone: _____ Relationship: _____

The information given to the office of Stanley R. Waddell DDS is true and I will notify the office of any changes. I hereby authorize any insurance benefits to go directly to Stanley R. Waddell DDS.

I understand that I am responsible for any balance not paid for by insurance.

SIGNATURE: _____ DATE: _____

MEDICAL HISTORY

PATIENT NAME: _____

Birth Date: _____

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 you will receive. Thank you for answering the following questions.

- | | | | |
|---|---------------------------|--------------------------|-------------------------------|
| Are you under a physician's care now? | <input type="radio"/> Yes | <input type="radio"/> No | If yes, please explain: _____ |
| Have you ever been hospitalized or had a major operation? | <input type="radio"/> Yes | <input type="radio"/> No | If yes, please explain: _____ |
| Have you ever had a serious head or neck injury? | <input type="radio"/> Yes | <input type="radio"/> No | If yes, please explain: _____ |
| Are you taking any medications, pills or drugs? | <input type="radio"/> Yes | <input type="radio"/> No | If yes, please explain: _____ |
| Do you take, or have you taken, Phen-Fen or Redux? | <input type="radio"/> Yes | <input type="radio"/> No | _____ |
| Are you on a special diet? | <input type="radio"/> Yes | <input type="radio"/> No | _____ |
| Do you use tobacco? | <input type="radio"/> Yes | <input type="radio"/> No | _____ |
| Do you use controlled substances? | <input type="radio"/> Yes | <input type="radio"/> No | _____ |

Women: Are you _____

Pregnant / Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following? _____

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain: _____

Do you have, or have you had, any of the following? _____

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Arthritis / Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problem	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack / Failure	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/ Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart Pace Maker	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No	Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble / Disease	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No		

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ DATE _____

How to Reach Our Office

We are located near the southwest corner of Poplar Avenue and Kirby Parkway, just south of the Bank of Bartlett, and directly across the street from the Carrefour shopping center.

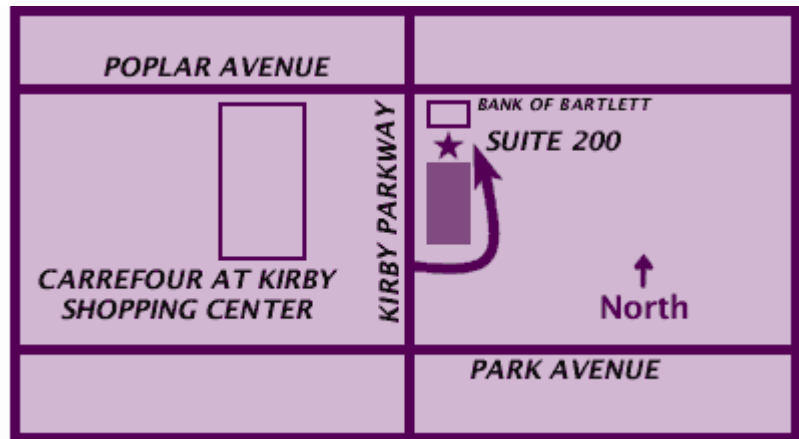
Our address is:

Stanley R. Waddell, DDS
1900 Kirby Parkway, Suite 200
Germantown, TN 38138

Our telephone number is:
(901) 756-8855.

Our email address is:
swaddell@drwaddell.com.

We invite you to call us for an appointment. We look forward to helping make you proud to show your smile to the world!



Our Philosophy of Practice

- We are committed to using continuing education and innovative technology to provide the finest in complete dentistry.
- Our patients value and appreciate the highest caliber of treatment, and invest in their health and well-being.
- We are a family who work together to deliver superb, sensitive care and service.
- A satisfied and healthy patient is our ultimate reward.