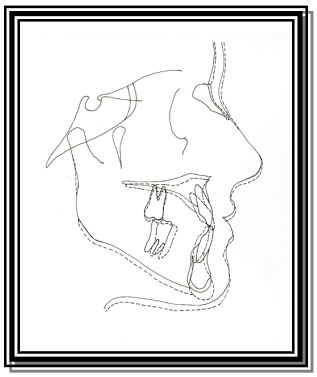

Michael T. Henry, DDS, MS, PA
105 Turnberry Way • Pinehurst, NC 28374

Patient _____

SS# _____ - _____ - _____

Date _____ / _____ / _____

Patient Information

Name_____ Birthdate_____ / _____ / _____ Home Phone_____

Address_____ City_____ State_____ Zip_____

Check Appropriate Box: Minor Single Married Divorced Separated

Patient's or Parent's Employer_____ Work Phone_____

Business Address_____ City_____ State_____ Zip_____

Spouse or Parent's Name_____ Employer_____ Work Phone_____

If Patient is a Student, Name of School/College_____ City_____ State_____

Whom May We Thank for Referring You?_____

Person to Contact in Case of an Emergency_____ Phone_____

Responsible Party

Name of Person Responsible for this Account_____ Relation to Patient_____

Address_____ Home Phone_____

Driver's License #_____ Birthdate_____ / _____ / _____ Bank_____

Employer_____ Work Phone_____

Currently a Patient in our Office? Yes No

Primary Insurance

Subscriber_____ Relationship to Patient _____ Birthdate _____

Social Security #_____ Employer_____ Work Phone_____

Insurance Company_____ Group #_____

Address_____ City_____ State_____ Zip_____

Secondary Insurance

Secondary Subscriber_____ Relationship to Patient _____

Birthdate _____ Social Security #_____

Insurance Company_____ Group #_____

Address_____ City _____ State _____ Zip _____

Dental History

Reason for Today's Visit_____

Former Orthodontist_____ Prior Orthodontic History_____

Current Dentist_____ Date of Last Dental Visit_____ Date of Last X-Ray_____

Check if you have had any of the following:

Bleeding gums	Loose teeth	Sensitivity to cold
Clicking or locking jaw	Missing teeth	Thumb or tongue habit
Food collection	Periodontal treatment	Trauma to your teeth
Grinding teeth	Sensitivity to heat	Trauma to your jaws

How often do you floss?_____ How often do you brush?_____

Medical History

Physician's Name_____

Have you ever had any serious illnesses or operations? Yes No If yes, describe_____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates_____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check if you have had any of the following:

Anemia	Cortisone Treatments	Hepatitis	Scarlet Fever
Arthritis, Rheumatism	Cough, Persistent	High Blood Pressure	Shortness of Breath
Artificial Heart Valve	Cough Up Blood	HIV/AIDS	Skin Rash
Artificial Joint	Diabetes	Jaw Pain	Stroke
Asthma	Epilepsy	Kidney Disease	Swelling of Feet/Ankles
Back Problems	Fainting	Liver Disease	Thyroid Problems
Blood Disease	Glaucoma	Mitral Valve Prolapse	Tobacco Habit
Cancer	Headaches	Pacemaker	Tonsilitis
Chemical Dependency	Heart Murmur	Radiation Treatment	Tuberculosis
Chemotherapy	Heart Problems	Respiratory Disease	Ulcer
Circulatory Problems	Hemophilia	Rheumatic Fever	Venereal Disease

Medications You are Currently Taking:

_____

_____

_____

Allergies/Allergies to Medications:

_____

_____

_____

Authorization and Release

I have read and answered the above questions to the best of my knowledge. I understand that I am financially responsible for all charges whether or not paid by insurance.

_____ _____

Signature of patient or parent if minor. Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.