PATIENT REGISTRATION

GETTING TO KNOW YOU

Welcome To Our Family of Patients

Thank you for choosing our office for your dental needs. We are proud that you have chosen us to be a partner on your path to optimal health. We have a combined 65 years of experience and believe strongly that we don't heal our patients but are the facilitators as our patients take responsibility in their own healing process. This is where the partnership begins.

What makes our office different from most other dental practices is our ability to affect whole body health by focusing on the mouth since this is vital to overall health. With the latest in technology and the most up to date training, you will always receive treatment you can trust. At The Julian Center, we focus on you as an individual with unique needs. We take our diagnosis of patients' needs a step further than most dental facilities, because we treat the *cause of the problem* and not simply the *most current symptoms*.

As a new member of our family of patients you'll discover what others have, that we care about your well being and will work together to make the best decisions about you and your family's overall health. As we move forward in this partnership, we make the promise that *your* needs will come first at each and every visit.

Gene Sambataro, DDS
Cindy Sambataro, RDH

OUR MISSION AND GOALS

At The Julian Center for Comprehensive Dentistry, we believe strongly that a mission that speaks to our philosophy and purpose is crucial to our success. That's why we've taken the time to develop a mission statement that projects our commitment to quality dental care and unwavering compassion for our patients.

We will raise the bar for all other dental practices by providing the highest quality of non-toxic, biological dental services to individuals striving for comprehensive, whole-body wellness. We will offer advanced technology and education to support our patients in a setting designed for relaxation and comfort. Each patient will be treated as a unique individual by a team of like-minded, compassionate and gifted professionals, in order to create a positive dental experience.

TELL US ABOUT YOURSELF

A firm foundation is needed upon which to base recommendations for your health. Therefore, we ask that you complete the entire Registration and Health History form. The information you provide will ensure safe treatment, aid us in diagnosis and treatment planning as well as help identify any precautionary measures we may need to take to protect your health. The information you provide is ***STRICTLY CONFIDENTIAL.***

Patient's Name:			Date of Birth:		
Email Address:					
If Minor or Dependent, Parent or Guardian's Name:					
Relationship to patient:					
Street Address:	City :		State:	ZIP:	
Occupation:					
Place of Employment:					
Home phone:			Business phone:		
Cell :			Driver's Lic. #		
Social Security #____ (only if you are the responsible party for your insurance and it is used as an identifier)					
Marital Status:			Name of Spouse:		
Number of Children (or Siblings):					
Names/Ages					
Do you have dental insurance? Y N			Name of Policy Holder:		
Insurance Company Name:					
Insurance ID #			GROUP #		
Policy Holder's Employer:			Policy Holders Date of Birth: ___ /___ /_____		

Payment in full is expected at time of service, unless other arrangements have been made. For your convenience we accept cash, personal checks & credit cards. A deposit will be required to hold the time and date of your appointment. This will be credited toward your treatment. This deposit is non-refundable; if you need to reschedule your appointment we require a minimum of 48 business hours notice.

Your time is important to us. We do not run our office like a clinic with ten or more patients stacked up in the waiting room. The time we schedule for you is yours alone to receive the individual attention and quality care you deserve. So if you cancel or fail to show for your appointment, two people are hurt:

1. You, because you're not getting the care you need,
2. Another patient waiting for an appointment who is being prevented from receiving treatment,

So, please be on time and keep your appointments.

There will be a minimum charge of $150 for canceling an appointment with less than 48 business hours notice.

In case of emergency please contact (closest relative or friend):

Name:	Phone

*I understand that I am responsible for all costs of my treatment. *I authorize the release of any information relating to this claim. I have read and agree to the terms stated above and that all information is true.*

TELL US ABOUT YOUR 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 you will receive. Thank you for answering the following questions:

	Y	N	If Yes, please explain:
Are you under a physicians care now?			
Have you ever been hospitalized or had a major operation?			
Have you ever had a serious head or neck injury?			
Are you taking any medications, pills or drugs?			
Do you take, or have you taken, Phen-Fen or Redux?			
Have you taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?			
Are you on a special diet?			
Do you use tobacco?			
Do you use controlled substances?			
Do you drink alcohol?			
Do you drink coffee?			

Women: Pregnant or trying to get pregnant? *Y N*	Nursing *Y N*	Taking Oral Contraceptives: *Y N*

Are you allergic to any of the following: Place a check next to the items that apply.

	Aspirin		Penicillin		Codeine		Local Anesthetics		Acrylic	
	Metal		Latex		Sulfa Drugs		Other			

Please check those that are a part of your current or past medical history:

AIDS/HIV +	Y	N	Cortisone Meds	Y	N	Hemophilia	Y	N	Radiation Tx	Y	N
Alzheimer's	Y	N	Diabetes	Y	N	Hepatitis A	Y	N	Recent Weight Loss	Y	N
Anaphylaxis	Y	N	Drug Addiction	Y	N	Hepatitis B or C	Y	N	Renal Dialysis	Y	N
Anemia	Y	N	Easily Winded	Y	N	Herpes	Y	N	Rheumatism	Y	N
Angina	Y	N	Emphysema	Y	N	High Blood Press	Y	N	Scarlett Fever	Y	N
Arthritis/Gout	Y	N	Epilepsy or Seizures	Y	N	High Cholesterol	Y	N	Shingles	Y	N
Artificial Heart Valve	Y	N	Excessive Bleeding	Y	N	Hives or Rash	Y	N	Sickle Cell Disease	Y	N
Artificial Joint	Y	N	Excessive Thirst	Y	N	Hypoglycemia	Y	N	Sinus Trouble	Y	N
Asthma	Y	N	Fainting /Dizziness	Y	N	Irregular Heartbeat	Y	N	SNPS	Y	N
Atrial Fibrillation	Y	N	Frequent Cough	Y	N	Kidney Problems	Y	N	Spina Bifida	Y	N
Blood Disease	Y	N	Frequent Diarrhea	Y	N	Leukemia	Y	N	Stomach Disease	Y	N
Blood Transfusion	Y	N	Frequent Headaches	Y	N	Liver Disease	Y	N	Stroke	Y	N
Breathing Problem	Y	N	Genital Herpes	Y	N	Low Blood Pressure	Y	N	Swelling of Limbs	Y	N
Bruise Easily	Y	N	Glaucoma	Y	N	Lung Disease	Y	N	Thyroid Disease	Y	N
Cancer	Y	N	Hay Fever	Y	N	Lyme Disease	Y	N	Tonsilitis	Y	N
Chemotherapy	Y	N	Heart Attack/Failure	Y	N	MTHFR	Y	N	Tuberculosis	Y	N
Chest Pains	Y	N	Heart Murmur	Y	N	Osteoporosis	Y	N	Tumors/Growths	Y	N
Cold Sores/Fever Blisters	Y	N	Heart Pacemaker	Y	N	Pain in Jaw Joints	Y	N	Ulcers	Y	N
Congenital Heart Disorder	Y	N	Heart Trouble/Disease	Y	N	Parathyroid Disease	Y	N	Venereal Disease	Y	N
Convulsions	Y	N				Psychiatric Care	Y	N	Yellow Jaundice	Y	N

Have you ever had any serious illness not listed above? Y N

___

___

___

TELL US ABOUT YOUR DENTAL HISTORY

<table>
<tr><td>1.</td><td colspan="4">Date of last exam:</td></tr>
<tr><td>2.</td><td colspan="4">Type of service rendered:</td></tr>
<tr><td>3.</td><td colspan="4">What concerns you most?</td></tr>
<tr><td>4.</td><td>Have you ever had treatment for your gums, orthodontic treatment, root canal therapy or extractions?</td><td colspan="3">If so, please describe:</td></tr>
<tr><td>5.</td><td colspan="4">Have you ever had local anesthesia?
Any abnormal reaction?</td></tr>
<tr><td>6.</td><td colspan="4">When was the last complete series of dental X-rays taken?</td></tr>
<tr><td>7.</td><td>Are your teeth sensitive to: (Please circle)</td><td>Hot</td><td>Cold</td><td>Sweets</td></tr>
<tr><td>8.</td><td colspan="4">Do any teeth hurt when you chew?</td></tr>
<tr><td>9.</td><td colspan="4">Are you aware of any bad odor or taste in your mouth?</td></tr>
<tr><td>10.</td><td>Do your gums bleed w/o stimulation from: (Please circle)</td><td colspan="2">Brushing</td><td>Flossing</td></tr>
<tr><td>11.</td><td>Do you grind or clench your teeth during the: (Please circle)</td><td colspan="2">Day</td><td>Night</td></tr>
<tr><td>12.</td><td>Have you ever had: (Please circle)</td><td>Pain</td><td>Stiffness</td><td>Clicking in your jaw</td></tr>
<tr><td>13.</td><td colspan="4">Do you have pain in or near your ears?</td></tr>
<tr><td>14.</td><td colspan="4">Have your teeth drifted or moved from their normal position?</td></tr>
<tr><td>15.</td><td>Do you get cold sores or fever blisters?</td><td colspan="3">How often?</td></tr>
<tr><td>16.</td><td colspan="4">Have you experienced any growths or unhealed injuries?</td></tr>
<tr><td>17.</td><td>Does food catch between your teeth?</td><td colspan="3">If so, where?</td></tr>
<tr><td>18.</td><td colspan="4">Are you aware of the connection between dental disease and systemic health issues?</td></tr>
<tr><td>19.</td><td>Do you have any sleep disturbances including:</td><td>Snoring</td><td>Waking up fatigued</td><td>Waking up feeling on edge</td></tr>
<tr><td>20.</td><td>Do you chew on only one side of your mouth?</td><td colspan="3">If so, why?</td></tr>
<tr><td>21.</td><td>Do you have all of your teeth?</td><td colspan="3">If not, why?</td></tr>
<tr><td>22.</td><td colspan="4">Were you told why missing teeth should be replaced?</td></tr>
<tr><td>23.</td><td>How often do you brush?
Do you floss?</td><td colspan="3">Have you even been given instructions on the proper method of brushing?</td></tr>
</table>

MORE INFORMATION TO HELP US CARE FOR YOU

The information on this page will help us learn more about your medical and dental health from a biological perspective. Please answer the questions as completely as possible.

MEDICAL HISTORY

Do you see an alternative health practitioner, (i.e. nutritionist, chiropractor, naturopath, health psychologist, healer, etc)? If yes, please list the name, address, phone number and type of health practitioner you see.

OK To Contact Please Circle	Name and Address of Practitioner	Phone	Type of Practitioner
Y N			
Y N			
Y N			

Would you be interested in speaking with our Nutrition Expert to explore opportunities for improving your dental and overall health through nutrition?

Would you consider alternative therapies if your health insurance did not cover the services? What is your feeling about using alternative healing therapies such as supplements, herbs or homeopathies?

Do you use natural remedies? If so, what kinds and what have the results been?

Are you environmentally/or chemically sensitive? If exposed, what are your reactions/symptoms?

Do you believe your body has the innate intelligence and wisdom to heal itself?

Describe your medical history chronologically over the past 5 years:

When did your health concerns begin? Was there any significant event that occurred around this time?

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 this office of any changes in my medical status.

Signature of Parent or Guardian Date

Tell us about your dental experiences over the past 5 years:
What are your present dental concerns or complaints?
Do you have any incomplete treatment? If so, please tell us about it:
Are you aware of or concerned with dental material compatibility?
Are you aware of the relationship between your dental health and your overall health?
How committed are you to eliminating future dental problem (decay and gum disease)?
Do you believe it is possible to eliminate dental decay and gum disease?
Additional comments: