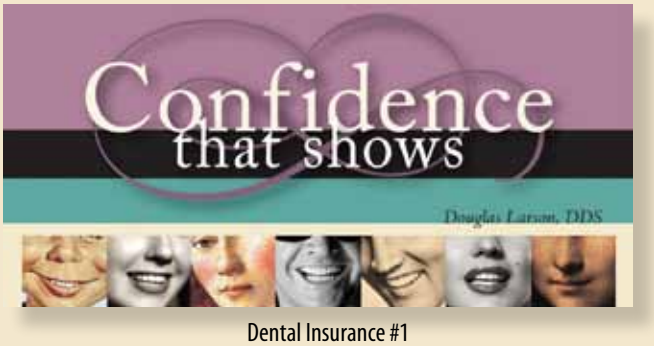
General History



Patient's Name: _____

Patient D.O.B. _____

Status ☐ Single ☐ Married ☐ Divorced

If Child: Parent's Name _____

Home Address _____

City _____ State _____ Zip _____

Phone: Residence _____

Cell Phone _____

Business Phone _____

E-mail _____

Employer _____

Business Address _____

Present Position _____

Responsible Party _____

S.S. # _____

Drivers Lic # _____

○ Cash ○ Credit Card

Who referred you? _____

Whom to notify in an emergency:

Name _____

Phone _____

Dental Insurance #1

Employee name _____

Employee D.O.B. _____

Employer _____

Insurance Comp. _____

Address _____

Policy # _____

Group # _____

S.S. # _____

Dental Insurance #2

Employee name _____

Employee D.O.B. _____

Employer _____

Insurance Comp _____

Address _____

Policy # _____

Group # _____

S.S. # _____

I authorize Dr. Larson to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits & health care, advice and treatment to another dentist. I hereby authorize payment of insurance benefits directly to Dr Larson. I understand that my dental care insurance carrier may pay less than the actual bill for services. I understand I am financially responsible for payment in full. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

We will gladly bill your insurance company for you. However, if we do not receive payment from them with in 35 days you will be responsible at time for the entire bill. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 1/2% late charge (18% APR) may be added to may account.

I release any photograph or radiograph materials for teaching purposes. I hereby authorize Dr Larson or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by Dr Larson to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize Dr Larson to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

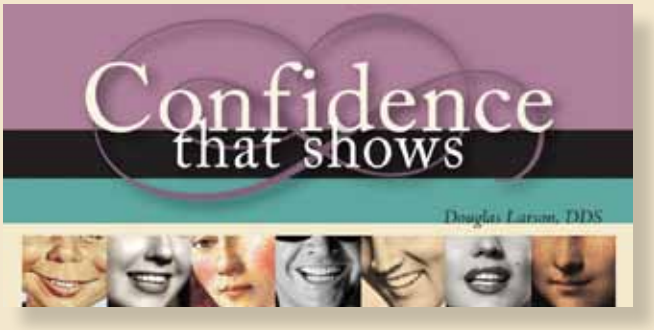
I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understated that I can ask for a complete recital of any possible complications. We ask for at least 2 business days advance notice for canceling or rescheduling an appointment; otherwise, a $75 fee may be assessed to your account.

Douglas K. Larson, DDS
42 West Campbell Ave.
Campbell, CA 95008
408 374 6160

Patient or Guardian Signature _____ Date _____

Medical History

Patient's Name: _____



Have you been under the care of a physician during the past 2 years? If so, for what? Physician's name & address.

Have you taken any prescription medications in the past 2 years? If yes, please list.

Are you aware of any adverse reactions to any drugs or medications? If yes, please list.

Are you taking any medications, drugs, or pills now? If yes, please list.

Have you been Hospitalized in the last 2 years? If yes, please describe.

Check if you have or had:

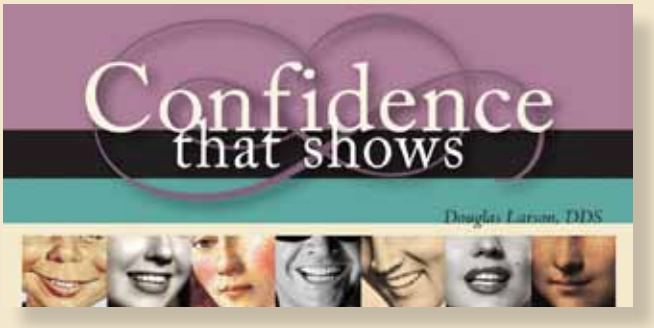
- ☐ Heart attack
- ☐ Heart surgery
- ☐ Chest Pain
- ☐ Heart defect
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Artificial Heart Valve
- ☐ Heart Pacemaker
- ☐ Rheumatic Fever
- ☐ Arthritis
- ☐ Rheumatism
- ☐ Cortisone Medicine
- ☐ Restricted Diet
- ☐ Artificial Joints
- ☐ Kidney trouble
- ☐ Stroke
- ☐ Ulcers
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Glaucoma
- ☐ Contact lenses
- ☐ Latex sensitivity
- ☐ Emphysema
- ☐ Chronic cough
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Hay fever
- ☐ Allergies or hives
- ☐ Sinus trouble
- ☐ Radiation therapy
- ☐ Chemotherapy
- ☐ Tumors
- ☐ Hepatitis A B C
- ☐ Venereal disease
- ☐ AIDS
- ☐ HIV positive
- ☐ Cold sores
- ☐ Fever blisters
- ☐ Blood transfusion
- ☐ Hemophilia
- ☐ Sickle cell anemia
- ☐ Bruise easily
- ☐ Liver disease
- ☐ Yellow jaundice
- ☐ Neurological disease
- ☐ Epilepsy / seizures
- ☐ Fainting / dizzy
- ☐ Nervous/anxious
- ☐ Psychiatric care
- ☐ Psychological care
- ☐ Women: are you Pregnant

my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient or Guardian Signature _____ Date _____

Douglas K. Larson, DDS
42 West Campbell Ave.
Campbell, CA 95008
408 374 6160

Dental History



Patient's Name: _____

Previous dentist's name: _____

When was your last dental examinations? _____

What is the reason for your visit today? _____

When was your last dental cleaning? _____

How often do you floss? _____

How often do you brush your teeth? _____

Date and treatment of last dental visit? _____

Last full mouth x-rays _____

What dental aids do you use? (Sonicare, floss, etc.) _____

List any current dental problems _____

Are any of your teeth currently sensitive to:

Hot or cold ☐ Yes ☐ No

Sweets ☐ Yes ☐ No

Biting ☐ Yes ☐ No

Discomfort when chewing ☐ Yes ☐ No

Do your gums bleed or hurt? ☐ Yes ☐ No

Have your parents experienced gum disease or tooth loss? ☐ Yes ☐ No

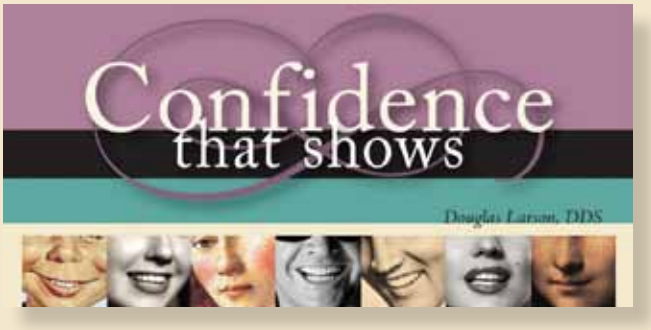
Do you have any loose teeth or a change in your bite? ☐ Yes ☐ No

Does food become caught between your teeth? ☐ Yes ☐ No

Do you frequently get: cold sores, blisters? ☐ Yes ☐ No

Douglas K. Larson, DDS
42 West Campbell Ave.
Campbell, CA 95008
408 374 6160

Dental History



Mouth odor or bad taste? ☐ Yes ☐ No

Do you smoke or chew tobacco? ☐ Yes ☐ No

Do you clench or grind your teeth? ☐ Yes ☐ No

Mouth breathe while asleep? ☐ Yes ☐ No

Tired jaw muscles? ☐ Yes ☐ No

Have you had orthodontic treatment? ☐ Yes ☐ No

Have you had any oral surgery? ☐ Yes ☐ No

Periodontal treatment? ☐ Yes ☐ No

Has your bite been adjusted? ☐ Yes ☐ No

Wear a night guard or mouth guard? ☐ Yes ☐ No

A serious head / mouth injury? ☐ Yes ☐ No

Clicking or popping of the jaw? ☐ Yes ☐ No

Pain in your ear, TMJ, or side of face. ☐ Yes ☐ No

Difficulty opening / closing mouth? ☐ Yes ☐ No

Difficulty in chewing ☐ Yes ☐ No

Headaches or neck aches? ☐ Yes ☐ No

Do you feel nervous about having dental treatment? ☐ Yes ☐ No

If so, what is your biggest concern? _____

Are you satisfied with your teeth's appearance? _____

Please describe any upsetting dental experience? _____

Patient / Guardian Signature _____ Date _____

Douglas K. Larson, DDS
42 West Campbell Ave.
Campbell, CA 95008
408 374 6160