

Name: _____ Date of Birth: _____

Full Address: _____

Email: _____

Home Phone #: _____ Cell Phone #: _____

How would you like to receive appointment reminders? Email or Text (please circle preference/consent)

Emergency Contact: _____

Relationship to Client: _____ Phone: _____

Physician name & town _____ Phone: _____

Pharmacy name & town _____ Phone: _____

Who may we thank for referring you to our office? _____

DENTAL INSURANCE: Policy Holder () Self () Spouse () Other Employer: _____

Ins. Company: _____ Policy# _____ I.D. # _____

HEALTH HISTORY

- Have you experienced a cardiovascular event within the past 6 months? YES NO
- If yes, please circle: Heart Attack Stent Valve Replacement Stroke Date? _____
- Have you ever had a joint replacement? YES NO If yes; when? _____
- Please list any medications you are presently taking _____
- Do you have any allergies? _____
- Have you ever been told you should take an antibiotic before dental treatment? YES NO
- Have you ever taken any osteoporosis (bone strengthening) medications or injections? YES NO
Examples: Alendronate (Fosomax), Editronate (Didrocal), Risedronate (Actonel) or Pamidronate (Aredia)
- Have you ever had a peculiar or adverse reaction of any of the following? (Please Circle)
Latex Nitrous Oxide Local Anaesthetic (Dental Freezing) Penicillin Aspirin Other? _____
- Have you ever had a problem with alcohol or drug dependency? YES NO If yes, please explain:

- Do you smoke? YES NO How much? _____
- **For women only:** Do you take birth control pills? YES NO Are you pregnant? YES NO

DO YOU NOW, OR HAVE YOU EVER HAD THE FOLLOWING (Please Circle)

Aids / HIV	Depression	Hepatitis A B C	Radiation / Chemo
Allergies Or Hives	Diabetes Type 1 Or 2	Herpes	Rheumatic / Scarlet Fever
Anemia	Emphysema	High/Low Blood Pressure	Sickle Cell Disease
Angina	Epilepsy Or Seizures	Hyper (Hypo) Glycemia	Sinus Trouble
Arthritis / Rheumatism	Fainting / Dizzy Spells	Hypertension	Stomach / Intestinal Issues
Artificial Joint (hip, knee, shoulder)	Gerd / Acid Reflux	Kidney Disease	Stroke
Anxiety / Nervousness	Head / Neck Injuries	Liver Disease	Thyroid Disease
Asthma	Heart Disease / Attack	Malignant Hyperthermia	Tuberculosis
Blood Disorders	Heart Murmur	Mental Illness	Venereal Disease
Bruise Easily	Heart Pacemaker	Mitral Valve Prolapse	Yellow Jaundice
Cancer	Heart Rhythm Disorder	Organ Transplant	Other? Please add below.
Congenital Heart Lesions	Heart Surgery	Osteoporosis	
COPD	Hemophilia	Pain In Jaw	

TREATMENT CONSENT / RELEASE OF INFORMATION/ PRIVACY POLICY

I, the undersigned hereby authorize the dentist to perform diagnostic procedures, as required to determine necessary treatment. I have provided an accurate personal and medical/dental history and have not knowingly omitted any relevant information. I understand that the information provided may need to be shared with my medical doctor or another health care provider and I consent to release of this information. We are committed to keeping your personal information private and a copy of our Private Policy is available in the reception area. I understand that the responsibility for payment for dental services provided in this office for myself and my dependants is mine. To keep costs down and to continue to provide quality dentistry, we can only accept payment in full the same day of service.

CANCELLATION POLICY

The goal of our practice is to provide quality treatment in a timely manner. To do so, it is necessary to implement an appointment cancellation policy. This policy enables the clinic practitioners to better utilize available appointment times for patients within the clinic, and for patients who require emergency care. Thank you in advance for your attention to this policy, we appreciate your consideration and courtesy.

If you need to cancel or reschedule an appointment your practitioner would appreciate 48 hours notice. Missed appointments (no shows) will be billed at \$100 (excluding emergency situations and due to illness).

Patient Name (PLEASE PRINT)

Parent/Guardian Name (if applicable)

Patient/Parent/Guardian Signature _____ Date _____