Patient Information

Patient Name: ____ Date: ____________

Last First MI (Preferred Name)

Date of Birth: __________ SSN: ______________ Family Status: ________ Driver's License #: ____________

Issue State: ____________

Phone (Home): ______________ (Cell): ______________ (Work): ______________

Mailing Address: ____

Street Apartment #

____________________________________ E-Mail: ______________________

City State Zip Code

Health Information

Date of Last Dental Visit: ______________ Reason for this visit: ______________________

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV
- ☐ Seasonal Allergies
- ☐ Autism
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Valve Replacement
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date: __________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ STD
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tobacco Smoker (past or present)
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ **Codeine Allergy**
- ☐ **Latex Allergy**
- ☐ **Metal Allergy**
- ☐ **Penicillin Allergy**

OTHER :

- ☐ ______________________
- ☐ ______________________

Please list all prescriptions and/or over the counter medications you are currently taking:

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Pharmacy Name: ______________________ **Pharmacy Number:** (______) ______-________

- **Are you taking any type of blood thinners?** ☐ Yes ☐ No
  If yes, please list medicine name: ______________________________
- **Have you ever had any complications following dental treatment?** ☐ Yes ☐ No
  If yes, please explain: ______________________________
- **Have you been admitted to a hospital or needed emergency care during the past two years?** ☐ Yes ☐ No
  If yes, please explain: ______________________________
- **Are you now under the care of a physician?** ☐ Yes ☐ No
  If yes, please explain: ______________________________
- **Name of Physician:** ______________________ Phone: ______________
- **Do you have any health problems that need further clarification**? ☐ YES ☐ NO
  If yes, please explain: ______________________________
- **EMERGENCY CONTACT:** ______________________ **Phone:** ______________
  RELATIONSHIP: ______________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

______________________________ ______________

Signature of patient, parent or guardian Date

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient (friend) ☐ Another patient (relative)

☐ Internet ☐ Insurance ☐ Newspaper ☐ Postcard ☐ Other ______________________________

Name of person or office referring you to our practice: ______________________________

HIPAA

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Please print name

I, ______________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: ______________________________ **Date:** ____________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ______________________________

Relationship to Patient: ______________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

I give you permission to share my personal information with my Dental Insurance Company and the following people:

Name: ______________________________ Relationship: ____________________

Name: ______________________________ Relationship: ____________________

Name: ______________________________ Relationship: ____________________

Please take a few moments to answer the following questions so that we can address all of your questions and concerns.

1. Are you interested in whitening your teeth?	YES	NO	UNSURE
2. Are you interested in straightening your teeth?	YES	NO	UNSURE
3. Would you like to change the appearance of your smile with veneers?	YES	NO	UNSURE
4. Would you be interested in easing TMJ pain with Botox injections?	YES	NO	UNSURE
5. Would you like to learn more about replacing missing teeth?	YES	NO	UNSURE

Other: ______________________________

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No Show/Cancellation Policy

We recognize that everyone's time is valuable; patients and doctors alike. For that reason, we kindly request a 48-hour notice if you must cancel an appointment. Failure to appear to a scheduled appointment not only compromises your health, but inconveniences other patients who may have requested an office visit during your scheduled appointment time. We also understand that emergencies happen and will do our best to accommodate you in any way that we can in case of such an emergency. **Therefore, if you cancel within 24 hours or no show an appointment, you will be charged a $75.00 non-refundable cancellation fee.** For excessive cancellations or missed appointments (3 in a 12 month period), you will be required to pay a $75.00 deposit to schedule a hygiene appointment, and/or you will be required to pay 100% of your patient portion to schedule for restorative treatment. These deposits will be applied toward services rendered . A $75.00 fee will only be withheld from your deposit if you cancel or no show within 24-hours of your scheduled appointment. If you have an appointment on a Monday that must be canceled over the weekend, please contact us via email or by calling and leaving a voicemail at the office's main phone number so that you will not be subject to the cancellation fee.

By signing here, you are acknowledging that you have thoroughly read and understand the no show/cancellation policy.

____ ______________________________

Signature **Date**