## 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:**

_____

_____

**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: _____

_____

_____

_____

# No Show/Cancellation Policy

We recognize that everyone's time is valuable; patients and doctors alike. 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.

**Cancellations made with less than 24 hours notice* will be documented in your chart as a missed or canceled appointment.** Patients with excessive cancellations or missed appointments will be required to pay a **$75.00 deposit in order to reschedule hygiene appointments and 100% of their patient portion to reschedule restorative appointments with the doctor.** These deposits can be taken over the phone upon scheduling and will be applied on your account to use toward future treatment. A $75.00 fee will only be withheld from your deposit if you cancel or no show that appointment within 24-hours* of your scheduled appointment.

By signing here, we enter into a relationship of mutual respect for your time and ours. You are also acknowledging that you have thoroughly read and understand the no show/cancellation policy.

_____ _____

**Signature** **Date**

*Cancellations the day before will count as a missed/canceled appointment.