PLEASE PRINT LEGIBLY SO WE CAN READ WHAT YOU WRITE, THANK YOU

Today's date_____ **(*Office Use) Staff*** _____ ***Chart #*** _____

MEDICAL HISTORY (Please fill out all that apply)

Allergies: _____

Medications you are taking: _____

LAST PHYSICAL: _____ **PHYSICIAN:** _____**Phone #:**_____

	Yes	No		Yes	No	
Heart Disease:	____	____	Tuberculosis:	____	____	
Kidney Disease:	____	____	Diabetes	____	____	Type I Type II
Liver Diseases:	____	____	Blood Disorders	____	____	
HIV:	____	____	Joint Replacements	____	____	Hip Knee Other
Hepatitis (A, B, C)	____	____	Abnormal bleeding	____	____	
High Blood Pressure	____	____	Heart Attack	____	____	
Pregnant (women)	____	____	STD's	____	____	_____

Other: _____

DO YOU NEED TO BE PREMEDICATED FOR DENTAL WORK? ____ ____ Not sure?

Dental History:

Last visit to a Dentist: _____ Former Dentist: _____

Last Cleaning and Check-up: _____ Last X-rays: _____

Referred by: _____

Reason for today's visit: _____

This Office's Cancellation, Missed Appointment and Collection Policies.

Our Office requires the courtesy of a minimum 48-hour notice (72 hours if the appointment is made for a Monday or any Tuesday following a Monday Holiday) to cancel any scheduled appointment. We make every effort to confirm your appointments in advance based upon the contact data you provide to us. It is the Patient's sole responsibility to update their contact data and to provide us with any required cancellation notices as noted above. This office reserves the right to charge missed appointment fees of $50 for cleaning and check-up appointments and $100 for any operative, cosmetic, root canal and/or crown or bridge appointments missed and not cancelled as noted above. Emergency events that may result in a cancellation notice infraction will be taken under consideration. Missed appointment fees may be waived only at the sole discretion of this office.

Payment for services rendered is due and payable at the time of service unless prior payment arrangements have been made in advance and in writing. The Patient agrees to be responsible for any and all costs of collection, attorney fees, Court costs and Dr's time to attend any Court hearing on any collection matter and/or dispute that may arise under this agreement.

Agreed to by: Patient Signature: _____

Date

For minor (if applicable): _____ Age:_____