Name ______________________________ Date ______________

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	(circle)		(circle)		(circle)
AIDS/HIV Infection	Y N	Frequently Tired	Y N	Neurological Problems	Y N
Anemia/Blood Problems	Y N	Glaucoma	Y N	Psychiatric/Emotional Problems	Y N
Angina	Y N	Hay Fever/Allergies	Y N	Radiation Therapy	Y N
Arthritis	Y N	Heart Attack	Y N	Recent Weight Loss	Y N
Asthma	Y N	Heart Disease	Y N	Respiratory Problems	Y N
Cancer	Y N	Heart Murmur	Y N	Rheumatic Fever	Y N
Cardiac Pacemaker	Y N	Heart Trouble	Y N	Sexually Transmitted Diseases	Y N
Chest Pains	Y N	Hepatitis/Jaundice	Y N	Sinus Problems	Y N
Diabetes	Y N	High Blood Pressure	Y N	Stomach Trouble/Ulcers	Y N
Easily Winded	Y N	Kidney Disease	Y N	Stroke	Y N
Emphysema	Y N	Leukemia	Y N	Swollen Ankles	Y N
Epilepsy/Convulsions	Y N	Liver Disease	Y N	Thyroid Problem	Y N
Fainting/Seizures	Y N	Low Blood Pressure	Y N	Tuberculosis	Y N

OTHER ______________________________

Our goal is to provide you with the best dental care available in an efficient and timely fashion. To achieve our goal and reduce escalating administrative costs, we ask for your understanding and cooperation regarding the following office policies:

APPOINTMENTS: A minimum charge will be made for failed or cancelled appointments without prior notification of at least 24 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you.

SIGNATURE ______________________________ DATE ______________
(Parent or guardian, if patient is a minor)

PAYMENT/BILLING: Payment is expected at time services are rendered. Be prepared to pay any co-payments at time of service. Your insurance is a contract between you and your insurance company; therefore, it is your responsibility to know and understand your benefits package prior to your dental visit. We will gladly submit a claim for covered services to your insurance company. Please understand that you are financially responsible for all charges, whether or not paid by insurance.

SIGNATURE ______________________________ DATE ______________
(Parent or guardian, if patient is a minor)

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16

32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

Comments ______________________________