

WOMEN: Pregnant? Yes ___ No ___ Due Date _____ Nursing? Yes ___ No ___ Birth control? Yes ___ No ___

Circle if you have had or have any of the following:

Allergies	Diabetes	High Blood Pressure	Scarlet Fever
Anemia	Dizziness	HIV/Aids	Shortness of Breath
Arthritis	Epilepsy (Seizures)	Jaundice	Sinus Problems
Artificial Heart Valves	Excessive Bleeding	Jaw Pain	Skin Rash
Artificial Joints	Extremely Nervous	Latex Allergy	Stroke
Asthma	Fainting	Liver/Kidney Disease	Stomach Problems
Back Problems	Glaucoma	Mental Disorders	Sulfa Drugs
Blood Disease	Growths	Mitral Valve Prolapse	Swelling of Feet/Ankles
Cancer	Hay Fever	Nervous Disorders	Thyroid Problems
Chemical Dependency	Headaches	No Epinephrine	Tobacco Habit
Chemotherapy	Head Injuries	Pacemaker	Tonsillitis
Circulatory Problems	Heart Disease	Penicillin Allergy	Tuberculosis
Codeine Allergy	Heart Murmur	Radiation Treatment	Tumors
Cortisone Treatments	Heart Problems	Respiratory Disease	Ulcer
Cough (Persistent)	Hemophilia	Rheumatic Fever	Venereal Disease
Coughing up blood	Hepatitis A B C	Rheumatism	Other:

Medications (list Medications you are currently taking with reason)

Allergies:

Have you ever been advised to pre-medicate with antibiotics prior to a dental appointment? Yes No

AUTHORIZATION AND CONSENT FOR SERVICES

I acknowledge that I understand the Patient Privacy Notice and have been given a copy of my rights if requested. I authorize my insurance company (if applicable) to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I authorize the dentist to release all health information necessary to secure the payment for benefits. In addition, Advances in Dentistry may share my health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing your treatment. I understand that I am financially responsible for all charges whether or not paid by my insurance. Additionally, I understand that I will be given a *guesstimate* for services due in advance of insurance payment. If insurance does not pay as much as expected, I understand that I am responsible for the remaining payment in a timely manner. I have made the doctor aware of all medical conditions and drug allergies past and present and realize that there are risks involved with dental procedures. I understand that it may be recommended for me to consent with my medical physician before proceeding with treatment due to past/present medical conditions. *I also understand that if I cancel without giving 48 hours notice or do not show up to my appointment, I will be charged a minimum fee of \$35 up to 15% of my scheduled appointment.*

Payment is due in full at time of treatment unless prior arrangements have been approved.

_____ Date _____
Print Patient Name

Patient or Legal Guardian Signature