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**Welcome!**

We are committed to provide you with the best possible care and help you achieve your optimum oral health. To achieve these goals, we would like to explain our office policies.

**PATIENT RESPONSIBILITIES**

**DENTAL BENEFIT PLANS:**  ***For your convenience we are a PPO Provider Practice***. Before moving on with your appointment please verify with the Front Office if we are In-Network with your insurance. Your Dental Benefit is a contract between YOU or YOUR EMPLOYER and the DENTAL BENEFIT PLAN. Benefits and payments received are based on the Terms of the contract negotiated between YOU or YOUR EMPLOYER and the BENEFIT PLAN.

If we **ARE** a Contracted Provider with your Benefit Plan, **YOU ARE RESPONSIBLE** for your portion of the approved fee as determined by your plan. We are **REQUIRED** to **COLLECT** the **Patient’s Estimated Portion** (***ANY AMOUNT NOT COVERED BY THE DENTAL BENEFIT PLAN ex: CO-PAY, DEDUCTBLE, CO-INSURANCE***) in **FULL PAYMENT** at the time of Service**. *If we ARE NOT a Contracted Provider with your Benefit Plan, it is YOUR Full Responsibility to Pay the difference in Coverage.***

**Please be advised that all financial estimates we provide are STRICTLY ESTIMATES, as we are not guaranteed anything we are told by insurance companies over the phone. There are also many provisions of insurance plans that we may not be aware of. Although we strive to obtain as much information about your insurance as possible, it is ultimately your responsibility to know what your insurance does and does not cover. After we receive final payment from your insurance, any difference between what was estimated and what was paid will be refunded or billed to you, accordingly.**

**\*PAYMENTS: Payments are ALWAYS due at the time of service.\***

Payment is due in full at the time of treatment unless prior arrangements have been approved. There is finance charges applied to accounts when they go without payments (1/month). We use a collecting agency after 11 months of no payments received with finance/late charges applied prior. You will be responsible for any charges incurred for legal or collection services.

**APPOINTMENTS:** We reserve the Doctor and Hygienist’s time on the schedule for each patient procedure and are diligent about being On Time. For this reason, when a patient Cancels an appointment, it impacts the overall quality service we are able to provide. **Therefore, we require a 24hr notice to Re-Schedule or Cancel an Appointment.** With less than a 24hr Notice a Fee of ***$60.00*** will be applied. There is a grace period of 15 minutes if running late; passing that time will result in a ***Late Fee of $60.00***. We ask to be courteous about other patients and call in advance.

Please Sign below once you have Read and Understood Our Practice’s Guidelines. Thank You.

X Date

**Protecting the Confidentiality of Your Health Information**

It is our desire to communicate to you that we are taking the new Federal HIPAA (Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you delay treatment because you are concerned that your health history might be unnecessary made available to others outside of our office.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal Law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our variable patient.

We will use and communicate your Health Information ONLY for the purpose of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

**Notice of Privacy Practices**

All information that is obtained from you by this office is protected and kept confidential. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced.

**Uses and Disclosures**

* Your health information is accessed and used for healthcare related purposes only.
* Your protected health information is never sold, rented transferred, exchange, and/or used for non-healthcare related purpose including marketing activities without your written authorization.
* Your protected health information is disclosed to third-party entities without your written authorization for the purpose of treatment, to obtain payment for treatment and for healthcare operations.

For any purpose other than treatment, obtaining payment, healthcare operations, or certain circumstances, we will ask for your written authorization before using or disclosing your protected health information, you can revoke that authorization in writing at any time.

**Patient Rights**

* You have the right to request to inspect and/or receive a copy of your health information.
* You have the right to request an alternate means or location to receive communications regarding your health information.
* You have the right to request in writing to amend, correct, or delete any recorded health information within our possession.
* You have the right to request in writing to restrict some of the uses and disclosures of your health information.
* You have the right to request in writing an accounting of certain disclosures of your health information that were made by this office.

**\*\*Conditions and limitations may apply. If needed, please ask the Front Desk for further information.\*\***

**Changes to this Notice**: We reserve the right to change privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an update notice will be posted and a copy will be sent to you.

**CROWN DENTAL CARE – PATIENT INFORMATION**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_\_\_\_\_\_\_\_ Last: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

Home Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your preferred method of contact?

[ ] Home [ ] Mobile Home [ ] Work Phone [ ] E-Mail

Social Security number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Driver’s License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_ Sex: [ ] Female [ ] Male

Marital: [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed

**Dental Benefit Plan Information**

Primary Dental Plan Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured D.O.B: \_\_\_\_\_\_\_\_\_\_ Subscriber I.D/Enrollee ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number/ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental History Form**

Former Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

Date of Last Dental X-Rays: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Last Dental Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you left your previous dentist, what was the reason? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your goals in coming to our practice today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is important to you in a dentist or dental practice? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**At Home Oral Hygiene Care**

How often do you brush your teeth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often do you floss? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use mouthwash? Yes / No If Yes, which kind: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use any other dental home care products? Yes / No If Yes, which kind: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Circle Appropriate Answer** (Leave Blank if you do not understand the questions)

1. Are you currently experiencing dental pain or discomfort? Yes/ No

If yes, explain:

1. Do your gums bleed? Yes/ No

If yes, explain:

1. Are your teeth loose? Yes / No

If yes, explain:

1. Do you wear dentures or partial? Yes / No

If yes, explain:

1. Have you ever been told you have gum disease? Yes / No

If yes, explain:

1. Are your teeth sensitive to hot, cold, sweets or pressure? Yes / No

If yes, explain:

1. Have you ever had any clicking, popping or discomfort in the jaw? Yes / No

If yes, explain:

1. Do you brux or grind your teeth? Yes / No

If yes, explain:

1. Do you wear an occlusal guard? Yes / No

If yes, explain:

1. Have you ever had orthodontic treatment (braces) before? Yes/ No

If yes, explain:

1. Do you have any dry mouth? Yes / No

If yes, explain:

1. Does Food or floss catch between your teeth? Yes/ No

If yes, explain:

1. Have you had any problems or an upsetting dental experience associated with previous dental care? Yes/ No

If yes, explain:

1. Are you fearful of dentistry or have anxiety associated with dental treatment? Yes / No

If yes, explain:

1. Have you ever been pre-medicated for dental treatment? Yes/ No

If yes, explain:

1. Have you ever had a reaction to anesthetic used with your dental treatment? Yes/ No

If yes, explain:

1. Are you happy with your smile? Yes/ No

If No, please explain:

1. What would you change about the present condition of your mouth?
2. Is there anything else you would like us to know about your dental healthy or dental history? Yes/ No

If yes, explain:

**I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful dental history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient (Parent or Guardian) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Dentist Date

**Confidential Health History**

**I. Circle Appropriate Answer (Leave Blank if you do not understand the questions)**

Is your general health good? Yes \ No

If No, explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has there been a change in your health within the last year? Yes \ No

If yes, explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you gone to the hospital or emergency room or had a serious illness in the last three years? Yes \ No

If yes, explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you being treated by a physician now? Yes \ No If yes explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last medical exam? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason for exam? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had problems with prior dental treatment? Yes \ No

If yes, explain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last dental exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of last treating dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you in pain now? Yes \ No

If yes, explain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**II. Have you ever experienced any of the following? (Please Circle Yes or No for each)**

Yes / No Chest Paint (angina)

Yes / No Fainting spells

Yes / No Recent significant weight loss

Yes / No Fever

Yes / No Night Sweats

Yes / No Persistent cough

Yes / No Coughing up blood

Yes / No Bleeding problems

Yes / No Blood in urine

Yes / No Blood in stools

Yes / No Diarrhea or constipation

Yes / No Frequent urination

Yes / No Difficulty urinating

Yes / No Ringing in ears

Yes / No Headaches

Yes / No Dizziness

Yes / No Blurred vision

Yes / No Bruise easily

Yes / No Frequent vomiting

Yes / No Jaundice

Yes / No Dry mouth

Yes / No Excessive thirst

Yes / No Difficulty swallowing

Yes / No Swollen ankles

Yes / No Joint pain or stiffness

Yes / No Shortness of breath

Yes / No Sinus problem

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**III. Have you ever experienced any of the following? (Please circle Yes or No for each)**

Yes / No Psychiatric care

Yes / No Osteoporosis

Yes / No Thyroid disease

Yes / No Asthma

Yes / No Hepatitis

Yes / No Sexual transmitted disease

Yes / No Herpes

Yes / No Canker or cold sores

Yes / No Anemia

Yes / No Liver disease

Yes / No Eye disease

Yes / No Transplants

Yes / No Tuberculosis

Yes / No AIDS/HIV

Yes / No Surgeries

Yes / No Hospitalization

Yes / No Diabetes

Yes / No Family history of diabetes

Yes / No Tumors or cancer

Yes / No Chemotherapy

Yes / No Radiation

Yes / No Arthritis, rheumatism

Yes / No Emphysema or other lung disease

Yes / No Kidney or bladder disease

Yes / No Stroke

Yes / No Eating disorders

Yes / No Heart Disease

Yes / No Family history of heart disease

Yes / No Heart attack

Yes / No Artificial joint

Yes / No Stomach problems or ulcers

Yes / No Heart defects

Yes / No Heart murmurs

Yes / No Rheumatic fever

Yes / No Skin disease

Yes / No Hardening of arteries

Yes / No High blood pressure

Yes / No Seizures

Yes / No Cosmetic surgery

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IV. Are you allergic to or have you had a reaction to any of the following? (Please circle Yes or No for each)**

Yes/ No Aspirin

Yes/ No Penicillin or other antibiotics

Yes/ No Nitrous oxide

Yes/ No Valium or sedatives

Yes/ No Metal

Yes/ No Latex

Yes/ No Local anesthetic

Yes/ No Codeine or other opioids

Yes/ No Food

Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**V. Are you taking or have you taken any of the following in the last three months? (Please circle Yes or No for each)**

Yes / No Recreational drugs

Yes / No Over-the-counter medicines

Yes / No Weight loss medications

Yes / No Anti-Depressants

Yes / No Tobacco in any form

Yes / No Alcohol

Yes / No Bisphosphate (Fosamax)

Yes / No Herbal Supplements

Yes / No Antibiotics

Yes / No Supplements

Yes / No Aspirin

Opioids (e.g., Norco/Vicodin, Percocet, Percodan) If Yes, please explain reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all prescription medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**VI. Women Only (Please circle Yes or No for each)**

Yes / No Are you or could you be pregnant? If YES, what month? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes / No Are you nursing?

Yes / No Are you taking birth control pills?

**VII. All Patients (Please circle Yes or No for each)**

Yes / No Do you have or have you had any other disease or medical problems NOT listed on this form?

If YES, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes / No Have you ever taken Fen-Phen? If YES, when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes/ No **Is there any issue or condition that you would like to discuss with the dentist in private?**

*The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.*

*I authorize Dr. Farahmand to contact my physician.*

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Whom would you like us to contact in case of an emergency?**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any chance in my healthy and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Signature of Patient (Parent or Guardian) Date Signature of Dentist Date