Abnormal Blood Pressure? ❑ No ❑ Yes

If yes, what is it usually? S_____ /D_____

Are you allergic or have you had a reaction to:

a. Local anesthetics ❑ No ❑ Yes

b. Penicillin or other antibiotics ❑ No ❑ Yes

c. Aspirin ❑ No ❑ Yes

d. Codeine, Valium or other sedatives ❑ No ❑ Yes

e. Other_____

Are you a smoker? ❑ No ❑ Yes

If so, how much do you smoke per day?_____

What are your chief complaints? List from most to least important.

a. _____

b. _____

c. _____

Other symptoms (please write in) _____

_____

Please list any medications you are currently taking.

1. _____ 2. _____

3. _____ 4. _____

4. _____ 6. _____

FINANCIAL AGREEMENT

I, the patient/guardian, agree to be and hereby am fully responsible for total payment for procedures in this office. I understand that payment for dental services is due regardless of the benefits paid by my insurance company, and that if denied in part or in whole, payment in full becomes my responsibility. I understand that if I cancel or no show for an appointment with less than 24 hours notice, a fee will be charged. Any outstanding balance over 90 days will be turned over to a collection agency. At that time, I understand I will be responsible for the collection fee in the recovery of this debt.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider of agency, who may release such information to you. I will notify the doctor of change in my health and medication.

_____ _____ _____

Patient (Print Name) Patient Signature Date

Thank you for your time!