



Health History and Policy Update Form

Patient's name: _____

Verify verbally with front office:

Mailing Address Phone Email Insurance Group # Company Subscriber

Please list **ALL** (yep, don't skip this please) your current medications: _____

Please list **ANY** health conditions, allergies (other than seasonal), joint replacements in the past year and heart attacks in the past year: _____

Have you had any dental work done in the past year outside of our office such as wisdom teeth extractions with an oral surgeon, periodontal surgery, etc.? _____ If yes, discuss with front office.

Cancellation policy: I understand that if I don't give 2 business days notice before canceling or missing an appointment that I will be incur a \$49 missed appointment fee, which is not covered by insurance. Initials _____

I understand that the following are potential complications that can occur with any dental treatment, and although not common, they can occur to me: bruising or paresthesia (prolonged or permanent numbness) with anesthetic injections, TMJ (jaw bones and muscles) pain or problems from opening of the mouth for extended periods of time, soreness or swelling in and around the mouth from stretching and use of instruments, damage to adjacent teeth or prolonged sensitivity when work is done on any tooth, if cavities are larger than expected the price may increase and sometimes a root canal may be needed if cavity is larger than expected. Emails to you and to specialists for you are done via a normal, unencrypted gmail account, let us know if you prefer fax or another method of communication. Initials _____

I have had the chance to review the office financial policy and requested a personal copy of it if I so desired. Initials _____

Signature or initials for digital signature: _____

Name: _____ Date: _____