Medical/Dental History Form

Name: ____
Last Initial First

Address: ____
Street (apt#) City Postal Code

Home: ( ) ________________Cell: ( ) _________________Work: ( ) ________________

Date of Birth: D D / M M / Y Y Y Y Email: __________________________________

Occupation:______________________________ Employer:_________________________________

Emergency Contact: _______________________________ Phone: ( ) ______________________

Health Card #: ___________________________ Family Doctor:_____________________________

Doctor Address: ______________________________ Doctor Phone: ( )______________________

Do you have dental insurance? Y N If Yes please complete the following….

Primary Insurance

Company: _____________________________ Policy Holder: _______________________________

Policy/Plan/Group: _____________________ Certificate/I.D.:_______________________________

Policy holders Date of Birth: : D D / M M / Y Y Y Y Relation to Holder: _________________________

Secondary Insurance

Company: _____________________________ Policy Holder: _______________________________

Policy/Plan/Group: _____________________ Certificate/I.D.:_______________________________

Policy holders Date of Birth: : D D / M M / Y Y Y Y Relation to Holder: _________________________

Health History

Has there been any change in your general health? .... Y N

If YES please describe: ____

Are you being treated for any medical condition or have you been treated within the past 2 years? .... Y N

If YES please describe: ____

Are you currently being treated by a physician for a specific condition? .... Y N

If YES please describe: ____

Are your currently taking any medication? .... Y N

Name of Medication/Condition	Dose

Do you bleed or bruise easily? .... Y N

Have you ever been hospitalized? .... Y N

If YES please describe: ____

Have you ever received general anesthesia? .... Y N

Have you ever had an adverse reaction to local anesthetic? .... Y N

Do you have any allergies to medications? .... Y N

If YES please list: ____

Do you have any other allergies? .... Y N

If YES please list: ____

Do you currently have any of the following conditions? **(Please circle)**

Heart Murmur	Osteoporosis	Osteopenia	Rheumatic Fever
Heart Valve Replacement	Asthma	COPD	Sleep Apnea
Artificial Joint Replacement	Hepatitis A/B/C/D	Thyroid Disease	Mental Illness
Diabetes Type 1 / Type2	AIDS/HIV	Herpes / Cold Sores	Emotional Problems
High Blood Pressure	Heart Attack	Angina	Glaucoma
Diaphragmatic Hernia	Atherosclerosis	Stroke	Cataract Surgery (When? __________)
Kidney Disease	Liver Disease	Drug/Alcohol Abuse	Vitroretinal Surgery (When?) ________)
Cancer (Type___________)	Jaundice	ADHD	Hormone Replacement Therapy
Epilepsy	Pacemaker	Organ Transplant	Arthritis (Type___________)
Radiation Therapy	Steroid Therapy	Stress	Surgery to Head and Neck

Is there anything else the doctor needs to know regarding your medical health? .... Y N

If YES please explain: ____

Do you smoke? (Circle please) Y N Quit Tobacco / Cigars / Chew / Other

Amount/day: ________________________ for how long? __________ Quit Date: __________________

Females ONLY: Are you or could you be pregnant? .... Y N

Are you currently breastfeeding ? .... Y N

Dental History

Are you currently experiencing any pain or discomfort?.. Y N

Are any of your teeth sensitive to: ___ Cold? ___ Hot? ___Sweet? ___Biting?

If Yes, which teeth or areas? ____

Do you have difficulty chewing food or does food get stuck between your teeth? .... Y N

Are you unhappy with the overall appearance of your teeth? .... Y N

Have you ever had braces for straightening your teeth? .... Y N

Have you ever had an injury to your jaw or face? .... Y N

Does your jaw ever click or pop or cause pain upon opening or closing? .... Y N

Are you nervous during dental treatment? .... Y N

Reason: ____

PATIENT CERTIFICATION AND CONSENT

I the undersigned, certify that all the above medical and dental information is true to the best of my knowledge and that I have not omitted any pertinent information. I agree to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetics or other prescribed drugs as indicated. I will assume full responsibility for the fees associated with these procedures. I agree to the privacy policies posted in the reception area and consent to the electronic sharing of information with my insurance company for the purpose of processing insurance claims and determination of benefits. Unless other arrangements have been made assignment of benefits from your insurance company will be set up. My dental insurance plan is a contract between myself and my insurance company, not between my insurance company and my dentist. I authorize the dentist to treat me and I assume full responsibility for all fees. I am aware that 2 business days notice is required to change or cancel an appointment without charge.

____ ____

SIGNATURE (PARENT OR GUARDIAN IF UNDER 16) DATE

____ ____

DENTIST'S SIGNATURE DATE

Email and Text Communication

Byron Family Dental has a unique email and text messaging system for confirming booked appointments with us, and for offering reminders. Our system is defaulted to email communication, but text messaging is also available if you prefer. Confirmations are sent by email 2 weeks prior to your appointment and once you click the link to confirm, a second email will be sent 2 days prior to remind you. We also provide a reminder email or text when you are 30 days away from your check-up due date, and another if you should happen to be 30 days overdue. You may unsubscribe from this service at any time.

Would you like to enroll in this program? Y___ N___

If yes, please select your preferred contact method:

Email ____ Text______ Doesn't Matter____

Date: ______________________

Patient Consent

I have reviewed the information provided explaining how Byron Family Dental will use my personal information and the steps Byron Family Dental will take to protect my private information.

I know that Byron Family Dental has a privacy policy and I can request to review it at any time. I am aware that Byron Family Dental will not sell my private information to a third party.

I ________________________________ am a patient of Byron Family Dental and authorize them to obtain insurance information and contact other health professionals if necessary on behalf of my family and myself. I also give permission for my dental insurance claims to be sent electronically if possible.

______________________________________ ______________________________________

Print Name Signature

Appointment Policy

Short notice cancellations or no shows are a disappointment to everyone; it can interfere with treatment progress and creates scheduling issues for future treatment. We request that **2 business days** notice be given to change an appointment time. This allows us to manage and respect our doctors and hygienists time accordingly. We understand, in rare circumstances, that emergencies occur and these will be assessed individually.

Our missed appointment fee of $50.00 will be collected and donated to the charity that our office has selected for that month, should significant notice of 2 business days not be provided.

We strive to accommodate the needs of all of our patients by providing the best possible dentistry, treatment options, and service available. We accomplish this by scheduling each patient their own individual time, reserved specifically for them. When an appointment is made, the appointment is firm. However, we do offer courtesy reminders via email or text message.

Our goal is to communicate to you, our valued patients, and our policy regarding broken appointments in order to avoid this from occurring.

______________________________________ ______________________________________

Print Name Signature