MEDICAL HISTORY FOR NAME: _____

	YES	NO	?
1. Have you ever had a serious illness requiring hospitalization or extensive medical care? Specify _____	☐	☐	☐
2. Have you been hospitalized in the past 5 years? Explain: _____	☐	☐	☐
3. Are you presently under the care of a physician? If so, explain: _____	☐	☐	☐
4. Have you had a medical examination in the last year?	☐	☐	☐
5. Do you use any prescription, non-prescription, or herbal medicine regularly? Specify 1) _____ 2) _____ 3) _____ 4) _____ 5) _____ 6) _____	☐	☐	☐
6. Do you smoke? _____ How much? _____			
7. Do you have any allergic condition: i.e. asthma, hay fever, latex, food or drug allergies? Specify _____	☐	☐	☐
8. Do any allergic reactions result in headache, shortness of breath, chest constriction, nausea Specify _____	☐	☐	☐
9. Have you ever experienced any unusual reaction to any of the following? Please circle: local anesthesia (freezing), aspirin, penicillin, erythromycin, iodine, sulfonamide, barbiturates (sleeping pills), codeine, or any other medicine? Explain: _____	☐	☐	☐
10. Have you been warned about taking any prescription drug or medication? If so, what? _____	☐	☐	☐

11. Do you have or have you had any of the following? Please check **all** that apply

☐ Heart murmur/mitral valve prolapse	☐ Malignant hyperthermia	☐ AIDS or contact	☐ Hepatitis A/B/C	☐ Liver disease
☐ Stomach/intestinal problems	☐ Drug/alcohol addiction	☐ HIV positive	☐ Herpes	☐ Cortisone steroid
☐ Joint replacement (hip, knee, ect.)	☐ Venereal disease	☐ Jaundice	☐ Heart attack/trouble	☐ Kidney disease
☐ Mental or nervous disorder	☐ Any lung disease	☐ Diabetes/family history	☐ Cold sores	☐ Stroke/Migraines
☐ High/low blood pressure	☐ Thyroid disease	☐ Arthritis or rheumatism	☐ Tuberculosis	☐ Anemia/blood disorders
☐ Hyper (hypo) glycemia	☐ Epilepsy or seizures	☐ Scarlet/rheumatic fever	☐ Sinus trouble	☐ Organ transplant /medical implant
☐ Cancer Type:	☐ Other			

12. Do you bruise easily or bleed abnormally?	☐	☐	☐
13. Do your ankles swell during the day?	☐	☐	☐
14. Have you ever had radiation treatment or chemotherapy? If so, explain: _____	☐	☐	☐
15. Do you have frequent earaches, ear/throat infections or any hearing difficulties?	☐	☐	☐
16. Is your eyesight: ☐ GOOD ☐ ADEQUATE ☐ POOR Do you wear contact lenses?	☐	☐	☐
17. Do you faint easily or often?	☐	☐	☐
18. Do you ever experience shortness of breath or chest pain when walking or climbing stairs? If so, explain: _____	☐	☐	☐
19. Do you have any disease or condition not listed above?	☐	☐	☐
20. WOMEN ONLY- Are you pregnant? If so, which month are you in? _____	☐	☐	☐
- are you taking birth control pills? _____	☐	☐	☐

DENTAL HISTORY

	YES	NO	?
1. Have you ever had injury, surgery or x-ray therapy to your face or jaws?	☐	☐	☐
2. Have you had a dental exam in the past year?	☐	☐	☐
3. Were x-rays taken?	☐	☐	☐
4. Do your gums bleed, feel tender or swollen?	☐	☐	☐
5. Do you have any pain in your teeth because of heat, cold, or sweets?	☐	☐	☐
If yes, where? _____			
6. Do you have any pain in your mouth while chewing?	☐	☐	☐
7. Do you ever clench or grind you teeth?	☐	☐	☐
If yes, when? _____			
8. Is there anything about your previous dental experience that we should be aware of?	☐	☐	☐
If so, explain _____			

INFORMED CONSENT/GENERAL RELEASE

I, THE UNDERSIGNED STATE THAT I HAVE PROVIDED AN ACCURATE AND COMPLETE MEDICAL/DENTAL HISTORY AND HAVE NOT KNOWINGLY OMITTED ANY INFORMATION. I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND RECEIVE ANSWERS REGARDING THIS MEDICAL/DENTAL HISTORY AND I CONSENT TO MY PHYSICIAN BEING CONTACTED IF NECESSARY. I AUTHORIZE THE DENTIST TO PERFORM DIAGNOSTIC, DENTAL AND ORAL SURGERY PROCEDURES AND SERVICES INCLUDING THE USE OF ANESTHETIC AS BE NECESSARY. I CONSENT TO PHOTOGRAPHS TAKEN DURING MY APPOINTMENT OR WHILE IN THE OFFICE AND UNDERSTAND THAY THEY MAY BE USED FOR DIAGNOSTIC, TEACHING/LEARNING AND/OR MARKETING PURPOSES.

Our Commitment

At Willow Dental Associate, we are committed to excellence. We feel that you deserve nothing less when it comes to your health. We use the best materials and techniques available in order to provide you with quality you have come to expect from us.

We believe that our relationship with you, as with all relationships, needs open and clear communication. We will try to communicate all of your dental needs and estimate your financial information as soon as it becomes evident. We want you to be as informed as possible to help you in your decisions concerning your dental health.

We understand how valuable your time is, so we make every effort to remain on time. We do not double book our appointments. We feel that you deserve our complete and focused attention so that we may provide the best care possible. Your reserved time is exclusively yours.

Your Commitment

We want you to be comfortable with our team. If you ever have any questions about your dental treatment, financial or insurance questions, or any concerns at all, we ask that you notify us as soon as possible. We will be glad to clarify any uncertainties that may arise.

Your portion of your dental treatment is expected at the time of your services. For you convenience we do accept many forms of payment including cash, cheque, Visa and MasterCard. In addition we also offer third party financing, which includes both interest free programs and extended financing.

Your scheduled appointment is reserved exclusively for you. We have a 2 business day cancellation policy in order to provide you with this personalized attention. We understand that circumstances may arise that require an appointment to be rescheduled. We are happy to change your appointment time if 2 business days notice are given. If sufficient notice is not given, your account will automatically be charged a $100 missed appointment fee. We ask that you make every effort to keep your reserved time.

PATIENT(PATIENT, GUARDIAN)SIGNATURE: _____

IF PARENT, GUARDIAN, PLEASE PRINT NAME: _____

DATE: _____

DOCTOR SIGNATURE: _____