

Do you have ,or have you had , any of the following?

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| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Rheumatic Fever* |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting/Dizzy Spells | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Heart Problems/Stroke | |
| <input type="checkbox"/> Artificial Joint* | <input type="checkbox"/> Heart Murmur* | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Pace Maker* | |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hemophila | |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Hepatitis A,B or C | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herpes | |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> High Blood Pressure | |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hypoglycemia | |
| <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Low Blood Pressure | |
| <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Mitral Valve Prolapse* | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Psychiatric Care | |
| <input type="checkbox"/> Drug addiction | <input type="checkbox"/> Radiation Treatments | |

*May require pre-medication prior to dental visits.

Do you use tobacco products? _____

Women Are you pregnant/trying to get pregnant ? _____

Have you ever had any serious illness not listed above? _____

Please list any medications you are taking at this time _____

PAYMENT POLICY

In an effort to control the cost of services we ask that payment be made at time of service. Arrangements can be made to pay for procedures which exceed \$200. If you would like assistance in filing your insurance claims, please provide the following information.

Subscriber name _____

Name of Insurance Company _____

Address _____ phone # _____

NOTICE OF CANCELLATION

Your account will be charged a cancellation fee of \$30 for all broken appointments without 24 hour notice.

SIGNATURE _____

DATE _____