Pat	atient Information	
Name	me	Married □ Single □ Minor □ Other □
Birth [n Date Social Security No	lidentify my gender as:
Addre	dress	
Cell p	I phone()	Email
Emer	ergency Contact: Name	Phone()
1.	. Preliminary Consent for Treatment I understand I am having any or all the following d	one today: Exam, Radiographs "X-rays" and cleaning "Prophylaxis"
		Initials
2.	reactions, resulting in redness and/or swelling of the Certain medications may cause drowsiness and it is	nditions dicines", anesthetics, latex and other substances can cause allergic etissue, itching, pain, vomiting and /or more severe allergic reactions. It is advisable not to drive or operate hazardous equipment when using any known allergies and/or medical conditions, including possible
		Initials
3.	out of respect for our other patients attempting to	es prevent you from coming to a scheduled appointment. However, secure appointments, if you are unable to keep an appointment, \$50 fee for any cancellations made within 24 hours of your reserved.
		Initials
4.		ny records (or my child's records) to carry out treatment, to obtain e operations that are related to treatment or payment. My consent roke it in writing.
		Initials
5.	and not necessarily based on what an insurance not cover all aspects of my treatment plan and l insurance plan. I understand that the treatment actual coverage may differ due to frequency liminsurance company, etc. I authorize payment directly payable to me. I acknowledge that I am response	nds is based on what he/she determines is best for my dental health, plan will pay. Therefore I understand that my Insurance (if any) may will be financially responsible for any treatment not covered by the plan proposed to me is an estimate of insurance benefits and my nitations, group coverage, incomplete information provided by my ectly to the dentist or dental group of insurance benefits otherwise ensible for any balance remaining in the event that my insurance n, I am aware any co-payments or payments will be due the day of
		Initials



Medical History

Please circle the appropriate answer, if you do not know the correct answer please write "DON'T KNOW" on the line after the question.

Physician's Name Address: Telephone: Are you under a physician's care? Mry? Since when Why? When was your complete physical exam? Are you taking any medications a substances? Are you taking any medications a substances? Are you larging to any medications of substances? Are you larging to any medications or substances? Bo you noutriely take health related substances? Are you alreging to any medications or substances? Bo you have any problems with penicifilia, antibiolics, anesthetics or other medications? Are you pregnant or suspect you may be? Are you aware of any heart murmurs? Are you aware had memantal fe wer? Are you aware taken fosamax. Jometo. Aredio or any other oral or intravenous treatment for fumor. Brown that or their condition? Are you aware had new problems? Are you aware taken fosamax. Jometo. Aredio or any other oral or intravenous treatment for fumor. Brown that or the condition? Are you aware taken fosamax. Jometo. Aredio or any other oral or intravenous treatment for fumor. Brown that or the condition? Are you aware to any offitical points/prosthess? Are you aware to any offitical points/prosthess? Are you dobted or you feet fosamax. Jometo. Aredio or any other oral or intravenous treatm	Patient Name		Birth Date
Address: Telephone: Are you under a physician's care? Why? When was your complete physical exam? Are you toking any medications or substances? If yes, please list medications in comments box.) Do you routherly take health related substances? If yes, please list medications in comments box.) Do you or hower any careful related substances? When we have a properties. Are you allergic to any medications or substances? Precess to you allergic to any medications or substances? Precess to you have any problems with penicillin, antibiotics, anesthetics or other medications? Are you pregnant or suspect you may be? No you but any problems with penicillin, antibiotics, anesthetics or other medications? Are you pregnant or suspect you may be? No you use any birth control medications? Are you are treated for or been told you might have heart disease? No you have a poacemaker, an artificial heart valve implant, or Been diagnosed with mitted valve prolappse? No you have a poacemaker, an artificial heart valve implant, or Been diagnosed with mitted valve prolappse? No you have to go we had a relation to relations? No you have whigh or low bload pressure? Impease one seat hyelf. No you have what and saidous illness or major surgery? No you have high or low bload pressure? Impease one seat hyelf. No you have what are diation freatment, chemo treatment for tumor, growth or other condition? No you have what are diation freatment, chemo treatment for tumor, growth or other condition? No you have any solidical pinits/prosthesis? No you have any bload disorders, such as amenta, seukemia, etc? No you have any bload disorders, such as amenta, seukemia, etc? No you have any bload disorders, such as amenta, seukemia, etc? No you have any bload disorders, such as amenta, seukemia, etc? No you have explained as a startilis or heart memorial pinits/prosthesis? No you have explained as a startilis or heart me			
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B. Do you have fainting or dizzy spells?	7. Are you diabetic?	N	
Do you have asthma?	3. Do you have fainting or dizzy spells?	N	
Do you have epilepsy or seizure disorders?			
Do you or have you had venereal or any sexually transmitted disease?			
R. Have you tested HIV positive?			
B. Do you have AIDS?	1. Do you of have you had verticed or any sexually indistrilled disease?	/ ht	
Have you had or do you test positive for hepatitis?	z. Have you tested hiv positive?	i N	
5. Do you or have you had T.B.?			
S. Do you smoke, chew, or snuff or any other forms of tobacco?			
N. Do you regularly consume more than one or two alcoholic beverages a day?			
B. Do you habitually use controlled substances?	6. Do you smoke, chew, or snuff or any other forms of tobacco?	N	
B. Do you habitually use controlled substances?	7. Do you regularly consume more than one or two alcoholic beverages a day?	N	
No. Have you had psychiatric treatment?			
D. Have you taken any prescription drugs fenfluramine, fenfluramine combined with Phentermine (fen-phen), dexafenfluramine (redux) or other weight loss products?			
Phentermine (fen-phen), dexafenfluramine (redux) or other weight loss products?	Have you taken any prescription drugs fenfluramine fenfluramine combined with		
Do you have any disease, condition, or problem not listed?	Phentermine (fen-phen) devafenfluramine (redux) or other weight loss products?	/ N	
If so, explain			
Nould you like to speak to the Doctor privately about any problems?		14	
CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE TIENT'S/GUARDIAN SIGNATURE		N	
CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE TIENT'S/GUARDIAN SIGNATURE	3. Would you like to speak to the Doctor privately about any problems?	N	
TIENT'S/GUARDIAN SIGNATUREDATE	increase to the first through		
NTIST'S SIGNATUREDATE			DATE
	ENTIST'S SIGNATURE		DATE

Clearly Cares Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

l,	have been informed of this office's Notice of		
Privacy Pra	ctices.		
Print Name			
Signature			
Date			
	FOR OFFICE USE ONLY		
We attemp	ted to obtain written acknowledgement of receipt of our Notice of Privacy but acknowledgement could not be obtained because:		
	Individual refused to sign		
	Communications barriers prohibited obtaining the acknowledgment		
	An emergency situation prevented us from obtaining acknowledgement		
	An emergency situation prevented us from obtaining acknowledgement		