Please answer the following questions as completely and accurately as you can. *Also, please* be as detailed as possible providing additional information you think is important. If you have any questions about this form, or your upcoming appointment, contact our office for assistance.

Medical History

General Health □ Good □ Fair Poor _____
Under Treatment □ Yes □ No Specify _____

Please list ALL drugs and medications you are currently taking

_____

_____

Herbal Medications _____
Diet Pills _____
Are you taking or have you ever taken Bisphosphonates □ Yes □ No

Please list ANY allergies to materials, drugs and medications

_____

HAS THE PATIENT EVER HAD ANY OF THE FOLLOWING?

Heart Attack or Stroke	Y	N	Intestinal Disorders	Y	N
Congenital Heart Defects	Y	N	Ulcers	Y	N
Heart Murmur	Y	N	Rheumatic Fever	Y	N
Heart Surgery/Pacemaker	Y	N	Epilepsy	Y	N
Mitral Valve Prolapse	Y	N	Fainting	Y	N
High Blood Pressure	Y	N	Head or Face Injury	Y	N
Low Blood Pressure	Y	N	Hearing Disorders	Y	N
Numbness of Arms/Hands	Y	N	History of Substance Abuse	Y	N
Ankle Swelling	Y	N	Nervous Disorder	Y	N
Other Heart Conditions	Y	N	Dizziness	Y	N
Diabetes	Y	N	Emotional Problems	Y	N
High/Low Blood Sugar	Y	N	Psychiatric Treatment	Y	N
Blood Disorders	Y	N	Thyroid Problems	Y	N
Liver Problems	Y	N	Birth Defects	Y	N
Bruises Easily	Y	N	Artificial Joints	Y	N
Kidney Problems	Y	N	Swollen, Stiff, Painful Joints	Y	N
Anemia	Y	N	Cancer	Y	N
Asthma	Y	N	Hepatitis	Y	N
Do you have an inhaler	Y	N	Herpes	Y	N
Pneumonia	Y	N	AIDS/HIV	Y	N
Emphysema	Y	N	Scarlet Fever	Y	N
Hay Fever	Y	N	Glaucoma	Y	N
Shortness of Breath	Y	N	Cosmetic Surgery	Y	N
Osteoporosis	Y	N	Sinus Problems	Y	N

I certify that the above information is correct to the best of my knowledge.
PATIENT/GUARDIAN SIGNATURE_____DATE_____

PLEASE ANSWER YES/NO AND EXPLANATIONS IF APPROPRIATE:

DENTAL HISTORY:

When was your last dental visit? _____
What did you have done? _____
What prompted you to seek dental care at this time? _____
Have you had any complications or negative experiences associated with previous dental treatment?
_____
How often do you floss your teeth? _____

YES NO Do your gums bleed when brushing?
YES NO Do you have an unpleasant taste or odor in your mouth?
YES NO Do you smoke?
YES NO Do you get food collection between the teeth?
YES NO Do you have any sores or growths in your mouth?
YES NO Are you concerned about your breath?
YES NO Have you ever had Periodontal Treatment? _____ _____
YES NO Have you lost any teeth? From what cause? _____
YES NO Have you ever had Oral Surgery? _____
YES NO Have you ever had Orthodontic treatment? When? _____
YES NO Have you ever had extensive dental treatment? When? _____
YES NO Do you wear dentures or partial dentures? Are they comfortable? YES NO
YES NO Is any part of your mouth sensitive to temperature, pressure, food or drink?
Where? _____

TMJ (JAW JOINT) HISTORY:

YES NO Do you get popping, clicking, or grinding noises when you open or close?
YES NO Have you ever been told you clench or grind your teeth during sleep?
YES NO Do you ever awaken with an awareness of your teeth or jaws?
YES NO Are you aware of clenching during the daytime?
YES NO Do you have trouble opening your mouth widely?
YES NO Does your jaw ever lock open or closed?
YES NO Do you have headaches/migraines? How often? _____
YES NO Do you have fainting or dizzy spells?
YES NO Do you feel like your sense of balance has changed?
YES NO Do your ears ring, buzz or hiss? How often? _____
YES NO Do your ears feel itchy, stuffy or congested?
YES NO Do you feel your bite is different, unstable or uncomfortable?
YES NO Have you ever had professional advice or treatment regarding your TMJ?
YES NO Have you ever been injured in an accident? When? _____

FOR WOMEN:

YES NO Are you pregnant? Expected delivery date? _____

I certify that the above information is correct to the best of my knowledge.
PATIENT/GUARDIAN SIGNATURE_____DATE_____

DENTAL QUESTIONNAIRE

If you could *change* anything about your smile which of the following would you want? (Check all that apply)

- ☐ Whiter
- ☐ Replace missing teeth
- ☐ Less gum showing
- ☐ Replace old plastic filling(s)
- ☐ Replace old crowns
- ☐ Remove stains on teeth
- ☐ Excess showing of teeth
- ☐ Replace chipped teeth
- ☐ Reshape/resize my teeth
- ☐ Remove silver fillings
- ☐ Straighter

In presenting your treatment plan and talking to the doctor please let us know which is best for you?

- ☐ I like just the basics and facts
- ☐ I like lots of information and details

I certify that the above information is correct to the best of my knowledge.
PATIENT/GUARDIAN SIGNATURE_____DATE_____

Please take a moment to read our office policies and feel free to ask any questions you may have

Kaleka and Brar Dental

It is important to us that the quality of our business services matches the quality of dental care. We want the handling of your account, from the start, to be perceived as an extension of the dental care we provide to you and your family. As with any partnership, both parties have a role to play. Our role is to provide you with quality treatment and service. In turn, your role is to pay for your treatment at the time of service. Our team will work with you to determine what financial arrangements work best for both of us. With an agreement made, our joint follow-through will result in a win for everyone.

CONSENT FOR TREATMENT

I hereby authorize the Kaleka and Brar Dental and designated staff to take x-rays, study models, photographs, electro-diagnostic studies and other diagnostic aids deemed appropriate to make a thorough diagnosis.

Upon such diagnosis, I authorize the Kaleka and Brar Dental and staff to perform all recommended treatment mutually agreed upon by me and to employ such professional assistance as required in order to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I authorize the release of a full report of examination findings, diagnosis, treatment program and ongoing progress report to any referring dentist, physician, chiropractor or other health care professionals as indicated on the physician contact list I provided. I additionally authorize the release of any medical information to insurance companies for legal documentation to process claims. **I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.**

AUTHORIZATION AND RELEASE

We file insurance claims for all patients with insurance benefits, however the balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance without complete insurance information. Your insurance is a contract between you and your insurance company and we are not a party to the contract. If your insurance has not paid on your claim within 45 DAYS, the full balance will automatically be transferred to you. That balance will be due upon billing.

Cancellation fee: We reserve the right to charge for any no show appointments or appointments not cancelled within 48 hours and are subject to a fee of $50.00 per hour of appointment time scheduled.

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

BY SIGNING BELOW YOU AGREE THAT YOU READ, UNDERSTAND, AND ACCEPT OUR FINANCIAL, CANCELATION, AND INSURANCE PHILOSOPHY AND POLICIES

I certify that the above information is correct to the best of my knowledge.
PATIENT/GUARDIAN SIGNATURE_____DATE_____