NAME:	COMPLETE MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? Yes No
   If yes, for what? ____
   Physician's Name: ____ Phone: ____
   Address: City: State: Zip: ____

3. Are you taking any medication, including herbs, vitamins and over-the-counter medications? Yes No
   Please List: ____

4 **Have you been told you need to take antibiotics prior to dental treatment:** Yes No

5 Have you ever taken Bisphosphonates (Fosamax, Actonel or Boniva)? Yes No
   Are you still taking the medication? Yes____ No____ How long did you take it for?

6 Are you aware of having an allergic (or adverse) reaction to any medication or substance? ____ Yes No
   If yes, please list:

7 Have you been a patient in the hospital during the past 6 months?____ Yes No
   If yes, please list:

8 Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A B C (circle)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact Lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

9 Have you been told you are a LOUD snorer? Yes No

10 Has someone told you, or have you noticed yourself, that you wake up gasping for air? Yes No

11 Have you ever been diagnosed with high blood pressure (hypertension)? Yes No

12 Have you had a sleep study? If yes, list diagnosis: Yes No

13 Have you been told to use a CPAP? Yes No
   If yes, are you able to wear your CPAP consistently? Yes No

14 Do you have dry mouth? If yes, list suspected reason: Yes No

15 Please list any disease, condition, or problem not listed:

16 **WOMEN:** Are you pregnant or think you may be pregnant? Yes No Months:____ Nursing? Yes No
17 **WOMEN:** Do you use birth control medications? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the dentist of any changes in my health or medication.

PATIENT/GUARDIAN SIGNATURE: DATE:

History Review

Dentist Signature ____ Date: ____

10330 Donner Pass Rd, STE A
Truckee, CA 96161
702-212-9622

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I____________________, have been advised of the Privacy Policies of the office and understand that I have the right to request a copy of the Notice of Privacy Practices.
Notice of our Privacy Practices is also available at www.tahoedentalartistry.com

CONSENT FOR TREATMENT

- I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of ___________________________ dental needs.
  (***Patient's Name***)
- Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required 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 give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
- I give Dr. Reid's office permission to forward any and all x-rays to a referring doctor when necessary.

Patient Signature ___________________________ Date ___________________________

Witness Signature ___________________________ Date ___________________________

Parent/Guardian Signature ___________________________ Relationship to Patient ___________________________

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FINANCIAL POLICY

Dental treatment has been proven to be directly linked to the individual's overall medical and psychological well being. We make every effort to remove financial considerations as an obstacle for this important health services.

PAYMENT INFORMATION

Patients are responsible for payment at the time of services.

If you need to make other financial arrangements with our office we are always ready to work with you.

Our office will be more than happy to complete your insurance claims and submit them to your Insurance Company. The claim reimbursement and /or explanation of benefits will be sent directly to the subscriber of the insurance policy.

FINANCE CHARGES AND COLLECTION ISSUES

A monthly interest rate of 1.5% will be applied to any unpaid balance, regardless of pending insurance after 30 days.

If a balance is in default and more forcible or thorough means are deemed necessary to collect, the undersigned agrees to pay, in addition to the total balance due and all applicable finance charges, all third party collection company fees, and /or attorney's fees of up to an additional 50% of the total balance outstanding at the time this matter is turned over to a collection company and /or attorney for collections; in addition to these fees, and all court costs, filing fees, processing fees and the like.

- I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made in writhing prior to treatment.
- If required, I also understand a check of my credit history may be required.
- Any returned checks from the bank are subject to a $35.00 dollar charge.

BROKEN APPOINTMENTS

Your appointment time is reserved exclusively for you. We strive to keep on time for all of our clients. If we are running behind we will try and call you ahead of time. We ask if you have any changes with your appointment you would notify us. We require 48 hours' notice to avoid broken appointment fee of $50.00 per ½ hour.

Patient Signature ____________________________ Date____________________________________

Witness Signature ____________________________ Date_____________________________________

Parent/Guardian Signature______________________ Relationship to Patient______________________