

_____ I understand there will be no fee charged as long as **48 hour notice** is given to cancel or change my appointment. Less than a 48 hour notice to cancel an appointment will result in a \$65 charge for every hour of time that was scheduled.

_____ I have received and understood the financial policies of Solaris Dental.

_____ I am aware that Solaris Dental follows protocol of HIPAA's notice to privacy laws.

SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT: _____

DENTAL HISTORY

Date of last visit: _____ Date of last X-rays: _____

Please indicate if any of the following conditions pertain to you:

<input type="checkbox"/> Bad breath	<input type="checkbox"/> Broken teeth/fillings	<input type="checkbox"/> Sores/Growth in mouth
<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Jaw pain, clicking or popping	<input type="checkbox"/> Periodontal treatment
<input type="checkbox"/> Tobacco habit	<input type="checkbox"/> Burning sensation on tongue	<input type="checkbox"/> Food collection in teeth
<input type="checkbox"/> Sensitive when biting	<input type="checkbox"/> Swollen/tender/bleeding gums	<input type="checkbox"/> Sensitive when biting

Health History

Please indicate if you have had any of the following:

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Fainting or dizziness	<input type="checkbox"/> Radiation Therapy
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Respiratory Disease
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Headaches	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Lesions	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Sinus trouble
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis Type _____	<input type="checkbox"/> Swollen Neck Glands
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Herpes	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Circulatory problems	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cortisone Treatment	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Tumor or Growth
<input type="checkbox"/> Cough, persistent	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> STD
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Nervous Problems	<input type="checkbox"/> Ulcer

Women are you Pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Medications: _____ Allergies: _____