Elysa P. Daniels, DDS, FAGD, PC
Blake J. Olson, DDS
P.O. Box 2268 – Carefree, AZ 85377
480-488-9735

Name:_____ Date:_____/_____/_____

Address:_____
(Number / Street) (City) (State) (Zip Code)

Occupation:_____ DOB:_____/_____/_____

Home Phone:_____ Cell Phone:_____

Emergency Contact:_____ Phone:_____

Previous Dentist:_____ Email:_____

Whom can we thank for referring you to our office:_____

Dental Insurance Information:

Policy Holder's Name:_____ DOB:_____/_____/_____

Social #: _____ Group #:_____

Employer:_____ Dental Ins. Phone: _____

Dental Ins. Mailing Address:_____

_____

_____

We are only providers for Delta Dental. For other insurance, as a service, we submit insurance claims for you and ask them to reimburse you.

Unless prior arrangements are made with our receptionist, we expect payment each time we provide treatment. This allows us to give you the best and most reasonable service possible without having to raise our fees. We appreciate your cooperation in this matter.

**Should you need any further information or clarification, the receptionist is happy to assist you.*

I fully understand and agree to the above policy and consent to treatment:

_____ _____
(Signature of patient or guardian) (Date)

Name:_____ Date:_____/_____/_____

Do you have, **or have you ever had**, any of the following:

1. Cardiovascular/Heart Problems: _____ Yes No

Any heart surgeries:_____ Yes No

2. Artificial Joints (If yes, which joints and when):_____ Yes No

_____

3. Pacemaker: _____ Yes No

4. High or Low Blood Pressure:_____ Yes No

5. Back Problems:_____ Yes No

6. Bleeding Disorder: _____ Yes No

7. Cancer (If yes, please specify):_____ Yes No

8. Stroke: _____ Yes No

9. Diabetes: _____ Yes No

10. Sleep Apnea:_____ Yes No

11. Hepatitis (If yes, what kind): _____ Yes No

12. Do you wear any oral appliances: _____ Yes No

13. HIV / AIDS:_____ Yes No

14. Herpes Simplex/cold sores: _____ Yes No

15. Acid Reflux/Gerd:_____ Yes No

16. Seizures or fainting spells:_____ Yes No

17. Are you allergic or have you had a reaction to: (please circle)

Local Anesthetics Penicillin(or other antibiotics) Sulfa Drugs

Aspirin Iodine

Other medication allergies:_____

18. Have you ever taken any osteoporosis medication:_____ Yes No

19. Food or seasonal allergies:_____ Yes No

20. Do you or have you ever smoked (How much per week):_____ Yes No

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Name:_____ Date:_____/_____/_____

21. Do you drink alcohol (How much per week): _____ Yes No

22. Drug Dependency:_____ Yes No

23. Psychiatric care: _____ Yes No

24. Tuberculosis:_____ Yes No

25. Arthritis:_____ Yes No

26. Do you have any disease or condition not listed above that you think I should know about:_____ Yes No

Women: Are you currently pregnant or nursing:_____ _____ Yes No

Are you currently taking birth control pills:_____ Yes No

Chief Dental Complaint: _____

Please list all medications and/or supplements you are currently taking:

Medication Name	Dosage

Please describe any recent medical treatment, impending operations or any other medical/dental information:

_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

(Signature of patient or guardian) (Date)