Blake J. Olson, DDS
Shannon K. Bischoff, DMD
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: _______________________

Referred by: ___________________________ Email: ___________________________

<u>Emergency Contact Info</u>:

Name:_____________________ Relationship:_______________ Phone:_________________

<u>Dental Insurance Information</u>:

Policy Holder's Name:______________________ DOB: ____ /___ /______

ID/Social #: ______________________________ Group #:_________________________

Employer:________________________________ Dental Ins. Phone: __________________

Dental Ins Name: ____

Dental Ins. Address: ____

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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. Seizures or fainting spells:____ Yes No

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

12. HIV / AIDS:____ Yes No

13. Herpes Simplex/cold sores: ____ Yes No

14. Sleep Apnea/cPAP:____ Yes No

15. Do you wear any oral appliances: ____ Yes No

16. Acid Reflux/Gerd:____ Yes No

17. Previous Orthodontic or Periodontal treatment:________________________________ Yes No

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

    Local Anesthetics   Penicillin(or other antibiotics)   Sulfa Drugs   Aspirin

    Other medication allergies:____

19. Have you ever taken any osteoporosis medication:________________________________ Yes No

20. Food or seasonal allergies:____ Yes No

21. Do you smoke? Yes No If you are a previous smoker, when did you quit? ____________

OVER ➡

Name:______________________________ Date:____/____/____

22. Do you drink alcohol (How much per week): ____________________ Yes No

23. Drug Dependency:____________________ Yes No

24. Psychiatric care: ____________________ Yes No

25. Tuberculosis:____________________ Yes No

26. Arthritis:____________________ Yes No

27. 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)