LaClair Family Dental
SMILE RIGHT...NOW

Welcome to our practice! We are thrilled that you have chosen us to provide your dental care, and look forward to meeting. Find out more regarding this amazing dental team at SMILERIGHTNOW.NET.

Your initial visit with us will include a comfortable, personalized, very thorough exam along with easy to understand information and choices about how we can help you achieve your oral health goals. Please plan to spend approximately 45-90 minutes with us.

Please read, complete (if you haven't already) and provide us these forms: HIPAA Privacy Policy, Financial Policy, Authorization for Radiographs, Records Release, Client Questionnaire and Medical History. These forms are very important to us, by having them completed in advance to your appointment, it gives our team ample time to become familiar with you.

If you have radiographs (X-rays) or other current records from your previous office, please use the enclosed release form to have them sent to us, directly from the previous dentist. If you have arrived without any records, know that all diagnostic services that are performed will be your financial responsibility.

As a courtesy to you, we will be happy to research your dental plan benefits to determine an estimate of what your plan may contribute toward your treatment. If you wish to receive this assistance, please be sure we have this information prior to your exam. Please bring your actual insurance card with you so we can keep a copy for our files. We provide detailed, electronic claims billing and are committed to maximizing your benefits. Payment is due at the time of service. Credit card options are offered to make your treatment affordable and convenient.

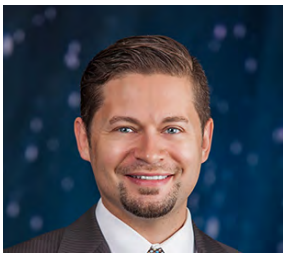
Your dental treatment will be uniquely customized for your needs. Our goal is to maintain and restore your teeth and gums in the most healthy, functional and comfortable manner possible! Your examination will include a specific plan based on the current condition of your teeth and gums-when you see your dental team you will soon realize that you have been cared for in a most thorough, comfortable, and complete manner.

We appreciate your busy schedule and are committed to reserving our facilities and time just for you. We insist that if you make an appointment, you honor it, which will keep our fees low, and prevent inconveniencing other patients. Trust that we will always honor your time to the greatest extent possible.

Once again, thank you for selecting our office. We are a referral practice, and almost all of our patients have found us through being invited by friends, family members or colleagues. We are excited to earn the right to your invitation as well! Please do not hesitate to let us know how we can serve you best.

Sincerely,

The LaClair Family Dental Team



Meet The Dentist

Born and raised in the North Country, Dr. Robert Allen LaClair III DDS (“Dr. Rob”) attended Hermon-DeKalb Central School, graduating Valedictorian in 1997. Earning a Bachelor’s degree majoring in Biology and minoring in Chemistry from LeMoyne College, Syracuse, NY, he was one of only three students accepted in the Class of 2001 to the 3/4 Affiliated Dentistry Program, receiving a commitment from dental school while still in high school. Dr. Rob moved on to the University of Buffalo School of Dental Medicine accomplishing his Doctorate of Dental Surgery degree in 2004, after 7 years, effectively skipping a year of college. While at University, Dr. LaClair’s main passion was complete esthetic full mouth reconstruction dentistry, which earned him The Edward C. Jauch Award for Comprehensive Care and the Delta Sigma Delta Operative Dentistry Award for Excellence in Restorative Dentistry. Dr. LaClair was awarded his dental license in the North East region after scoring highly on the patient treatment centered NERB exam. Dr. Rob graduated class of 2004 with certification in Diode Laser use and CEREC CAD/CAM robotic manufactured one visit crowns, bridges and veneers, which he practices on a daily basis.

Dr. Rob LaClair is a member of the American Dental Association, Fifth District New York State Dental Society, the Jefferson-Lewis County Dental Society as the current President, and the Academy of General Dentistry.

Dr. Rob strives to bring world class dentistry to the North Country. Since returning to Northern New York, Dr. LaClair has continued to expand his knowledge, regularly traveling the country for continuing education. His thorough training includes extensive knowledge and daily practice within these disciplines: Invisalign clear braces, Clear Correct braces, Conscious Sedation anxiety control certification, Lumineers veneers certification, MDI Implant Certification, Botox/Restylane Dermal Fillers certification, Six Month Smiles Certified Provider of cosmetic braces, extensive training in full mouth reconstructive dentistry, TMD (TMJ) therapy with specialized nighttime appliances and facial injections, and Obstructive Sleep Apnea therapy, among some of the countless other hours of continuing education he has received. He has practiced in The North Country since 2004, and Carthage, NY at LaClair Family Dental, since 2006.

Dr. LaClair has a unique perspective on dentistry and healthcare in general. His grandfather was a local surgeon with a large practice that spanned several decades and his uncle happens to be a practicing dentist. Of course, Dr. Rob has also been a dental patient. Sustaining a sports injury, he has been through root canals, posts, buildups, crowns, partial dentures, dental extractions, bone grafts, dental implants, you name it. Dr. Rob has also injected himself with novacaine. But, he has never had a cavity, simply by practicing the methods he teaches. All of this helps his sense of experience and compassion when treating his patients. A word from the Doctor:
“My team and I share a great sense of humility and respect when a person grants us permission to place our hands on them in the healing art that is dentistry. From the moment our painless injection technique is delivered, to the end of the day when I personally call my patients to check on them, every moment we are chair side with them we completely give ourselves to the process of making people happy and providing outstanding customer service. That is what I wish to give to all that will let me, no matter the background, socioeconomic status, or insurance carrier. We are all on this planet together, we should help each other make our community a better place, even if, or especially if, that means at the dentist’s office.” -Dr. Robert LaClair

In his free time, Dr. LaClair spends as much time as he can with his family: Kelly, Emma and Maverick. He is a self taught acoustic and electric guitar player, likes to learn about Buddhist philosophy, traveling as far as India to study with His Holiness the Dalai Lama. Being raised in the Northern New York area, and having his entire family living in Northern NY, Dr. Rob feels connected to the area in a strong way and feels fortunate to be a local business owner which provides employment to many dedicated, brilliant employees. Dr. LaClair looks forward to meeting you, your family, and friends, and welcomes you to become part of his practice.

Notice of Privacy Practices

PLEASE READ ALL THEN SIGN LAST PAGE AND RETURN.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Dental Practice Covered by this Notice

This Notice describes the privacy practices of LaClair Family Dental ("Dental Practice"). "We" and "our" means the Dental Practice. "You" and "your" means our patient.

II. How to Contact Us/Our Privacy Official

If you have any questions or would like further information about this Notice, you can contact LaClair Family Dental's Privacy Official at:

Theresa LaClair

111 South Mechanic Street

Carthage, NY 13619

315-493-1184

315-519-1545

theresa@smilerightnow.net

III. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to:

- Maintain the privacy of your protected health information;
- Give you this Notice of our legal duties and privacy practices with respect to that information; and
- Abide by the terms of our Notice that is currently in effect.

IV. Last Revision Date

This Notice was last revised on November 19, 2015.

V. How We May Use or Disclose Your Health Information

The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

A. Common Uses and Disclosures

1. Treatment. We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

2. Payment. We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

3. Health Care Operations. We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

4. Appointment Reminders. We may use or disclose your health information when contacting you to remind you of a dental appointment. We

may contact you by using a postcard, letter, phone call, voice message, text or email.

5. Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

6. Disclosure to Family Members and Friends. We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

7. Disclosure to Business Associates. We may disclose your protected health information to our third-party service providers (called, "business associates") that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use a business associate to assist us in maintaining our practice management software. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

B. Less Common Uses and Disclosures

1. Disclosures Required by Law. We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

2. Public Health Activities. We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

3. Victims of Abuse, Neglect or Domestic Violence. We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

4. Health Oversight Activities. We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

5. Lawsuits and Legal Actions. We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

6. Law Enforcement Purposes. We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

7. Coroners, Medical Examiners and Funeral Directors. We may disclose your health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

8. Organ, Eye and Tissue Donation. We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

9. Research Purposes. We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

10. Serious Threat to Health or Safety. We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

11. Specialized Government Functions. We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

12. Workers' Compensation. We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

VI. Your Written Authorization for Any Other Use or Disclosure of Your Health Information

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization. If a use or disclosure of protected health information described above in this notice is prohibited or

materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

VII. Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

A. Right to Access and Review

You may request to access and review a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

B. Right to Amend

If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

C. Right to Restrict Use and Disclosure

You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception: If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

D. Right to Confidential Communications, Alternative Means and Locations

You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an

alternative method of contact or alternative address and indicate how payment for services will be handled.

E. Right to an Accounting of Disclosures

You have a right to receive an accounting of disclosures of your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

F. Right to a Paper Copy of this Notice

You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

G. Right to Receive Notification of a Security Breach

We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information.

The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

VIII. Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this HIPAA Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

IX. Our Right to Change Our Privacy Practices and This Notice

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice is November 19, 2015.

X. How to Make Privacy Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.

By signing this I am acknowledging that I have read and understand LaClair Family Dental's Notice of Privacy Practices. I have been provided with a copy and have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that by signing this acknowledgment and consent form that I am giving consent for LaClair Famiy Dental's use and disclosure of my protected health information to carry out treatment, payment activities and health care options.

Patients Name _____ Date _____
(Please print)

Patient/Legal Guardian _____ Date _____
(Please circle one)

If this acknowledgment is signed by a personal representative on behalf of the patient, Please complete the following:

Personal Representative Signature _____ Date _____

Financial Policy

Full payment is due at the time services are rendered, including co-pay amounts, unless PREARRANGED PRIOR TO APPOINTMENT DATE. For your convenience we accept cash, personal check, money orders, Visa, MasterCard, Discover, CareCredit, H3, Complete Care, and Save Right...Now-Dental Savings Plan. Payment plans/financial arrangements can be made for dental treatment prior to the treatment appointment date. This is done with a signed, agreed upon plan of forward action in a financial arrangement form. In-house payment plans are not available. A fee of $30.00 will be billed to you for any checks returned by your bank.

Insurance benefits are determined by your employer, not your dentist. Insurance is not a guarantee of payment; it will not cover all your costs, and it is **only a form of PAYMENT, not a form of treatment.** Your insurance policy is a contract between you and your insurance company. Payment to LaClair Family Dental is strictly **your responsibility**. We will do our best to maximize all the benefits to which you are legally entitled. As a courtesy we will be glad to file your claim for you. Please provide us with your dental insurance card **prior to your appointment date** with required employer information.

Continuity and consistency of care are both key to maintaining proper dental health. Maintaining a relationship with our patients is our first priority. Individuals who have not been seen in the practice within **eighteen months** will be considered a new patient to the office. Your appointment is reserved exclusively for you; therefore a courtesy of advance notice when you are unable to keep an appointment is appreciated and **required**. We reserve the right to charge and **collect a fee of $50 for appointments that are cancelled or broken without 48 hours notice. Prepayment may be required to book any follow-up appointment.** Providing advance notice allows other patients who may have been waiting for an appointment the opportunity to be cared for. We reserve the right to dismiss any patient from the practice who misses or cancels, without 48 hours notice. Cancellations with less than 48 hours notice are considered missed appointments. **Appointment changes must be made directly through the office**. Leaving a message with an answering service/machine or on an automated system **is not acceptable**.

I have been given the opportunity to ask questions regarding this policy. I have read and understand its contents.

Patient/Guardian Signature _____ Date _____
(Please circle one)

98% of our valued patients pay their bill at time of service. We appreciate if you do the same.

Authorization for Radiographs

We are committed to delivering the highest quality and safety of care to each individual patient. LaClair Family Dental uses Digital radiography technology. This technique uses 90% less radiation, there is no wait time to develop and can be shown to you on the computer screen to show you what and where the problem is. If necessary, these images can be sent electronically to a specialist or another dentist if you move.

Radiographs (X-rays) are used to diagnose and monitor oral disease at the highest possible level, its important to have radiographs (X-rays) at your first visit and at recall visits.

Radiographs, **as long as they are legible**, can be brought from another dental office for us to reference. If radiographs are not brought to your first visit, we insist on taking our own to proceed with your examination. **You are responsible for this fee whether or not your insurance company will cover them.**

I am acknowledging I have read and understand the importance of radiographs and also my financial responsibility to LaClair Family Dental if my insurance will not cover essential radiographs (X-rays) needed to properly diagnose.

Patient/Guardian Signature _____ Date _____
(Please circle one)

The vast majority of patients choose to follow the ADA recommendations for recommended X-rays.

Authorization to Release Confidential Information

I, (Patient/Guardian) _____ hereby request and authorize:
(Please print name)

(Previous Dentist/Practice Name) _____
(Practice Address) _____
(Practive Phone Number) _____

to disclose and provide copies of any and all clinical treatment records and information concerning my care, which is in the possession of this person or entity, to:

LaClair Family Dental, PLLC
smilerightnow.net
111 South Mechanic Street
Carthage, NY 13619
Phone: (315) 493-1184
Fax: (315) 282-2403
Team Leader/contact: theresa@smilerightnow.net

These records include, but are not limited to: personal patient information, medical and dental histories, examination records, radiographs, clinical photographs, treatment plans, treatment records, referral/consultation recommendations and reports, diagnostic models, and any other related materials.
Please note: Receipt of your records **in advance of your appointment date** will provide the LaClair Family Dental team familiarity with your dental history in an attempt to **reduce your costs**.

Patient/Guardian Signature _____ Date _____
(Circle one and please print)

Member of: ADA-NYSDA-AGD

LaClair Family Dental
SMILE RIGHT...NOW

www.smilerightnow.net "Like" our Facebook 'LaClair Family Dental' for SPECIALS!

Client Questionnaire

Patient Name: _____

What is the best way to contact you? (Please include a phone number if applicable)

Text Message: ◯ Yes ◯ No #
Home Number: ◯ Yes ◯ No #
Post Card: ◯ Yes ◯ No
Work Phone: ◯ Yes ◯ No #
Mobile Phone: ◯ Yes ◯ No #
Email Message: ◯ Yes ◯ No

Please share your email with us as we would like to send you newsletters periodically about new products/information that interests you. _____

How did you hear about our office:

◯ LaClair Family Dental Facebook ◯ Cable TV ◯ LaClair Family Dental Website
◯ T.V. "Ask the Expert" ABC50 ◯ Yellow Pages ◯ Medical Directory

Friend/Family referral...Who? _____

Other way you heard about us: _____

Please casually answer to the best of your ability (0-not at all, 10-very much).

How important to you is your smile and your oral health? (Last time at dentist: _____)

0◯ 1◯ 2◯ 3◯ 4◯ 5◯ 6◯ 7◯ 8◯ 9◯ 10◯

Are you afraid of the dentist? **(Ask about our 'sleepy time dentistry' special.)**

0◯ 1◯ 2◯ 3◯ 4◯ 5◯ 6◯ 7◯ 8◯ 9◯ 10◯

Do you feel you have bad breath? **(Ask about our Halitosis (bad breath) treatments.)**

0◯ 1◯ 2◯ 3◯ 4◯ 5◯ 6◯ 7◯ 8◯ 9◯ 10◯

Do you have headaches, face, neck or jaw pain? **(Ask about face/head/neck pain relief.)**

0◯ 1◯ 2◯ 3◯ 4◯ 5◯ 6◯ 7◯ 8◯ 9◯ 10◯

Do you like your smile?

0◯ 1◯ 2◯ 3◯ 4◯ 5◯ 6◯ 7◯ 8◯ 9◯ 10◯

How do you sleep? 0-Terribly; 10-Fantastically **(Not great? Ask about improving your sleep.)**

0◯ 1◯ 2◯ 3◯ 4◯ 5◯ 6◯ 7◯ 8◯ 9◯ 10◯

Would you like your teeth straight in about 6 months for the price of a cup of coffee/day?

0◯ 1◯ 2◯ 3◯ 4◯ 5◯ 6◯ 7◯ 8◯ 9◯ 10◯

Are you interested in our specials on whitening products or cosmetic dentistry?

0◯ 1◯ 2◯ 3◯ 4◯ 5◯ 6◯ 7◯ 8◯ 9◯ 10◯

Are you interested in wrinkle removal or plumper lips? ◯ Yes ◯ No (Ask us how.)

Do you wear dentures? ◯ Yes ◯ No

Are you interested in dental implants? ◯ Yes ◯ No

If you could do anything to your smile, what would that be? _____

_____

_____

Here at LaClair Family Dental, new patients and emergencies are always welcome and we LOVE referrals! We take pride in having patients who are truly satisfied with our services and we hope to exceed your expectations. Please know that we will take your referral very seriously, and would treat those you send with the very best care and service around. We would also love to send you a note in the mail as a special thank you for the kind referral.

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____