WELCOME

Thank you for joining our periodontal practice. We appreciate your confidence in us and we will do everything possible to provide you with the finest periodontal care. Please fill out the following pages and ask if you have any questions.

PATIENT INFORMATION

TODAY'S DATE_____

LAST NAME FIRST M.I. NICKNAME

STREET NUMBER & NAME CITY & STATE ZIP CODE

HOME PHONE NUMBER BUSINESS PHONE NUMBER CELL PHONE NUMBER

EMAIL ADDRESS SOCIAL SECURITY NUMBER DATE OF BIRTH - AGE

FEMALE / MALE / OTHER

BUSINESS NAME OCCUPATION SEX

REFERRED BY WHOM: (name of dentist, or friend)

EMERGENCY CONTACT

NAME TELEPHONE RELATIONSHIP

MEDICAL HISTORY	MEDICAL UPDATES

Personal Physician's
Name:_____
Phone Number:_____
Please list any **serious medical problems** or surgeries you have
had:_____
_____
_____
_____
Please list any medications that you are now
taking:_____
_____
_____

Do you smoke? YES NO Use Marijuana? YES NO
WEIGHT:_____
HEIGHT_____
WOMAN: Are you pregnant? YES NO
Taking contraceptives? YES NO

Do you have or have you had any of the following:

___Artificial Joints	___ Anemia
___Artificial Heart Valve	___Aids/HIV+
___Circulatory Problems	___Cancer
___Drug/Alcohol Abuse	___Diabetes
___Excessive Bleeding	___Fever blisters
___Heart Murmur	___Hepatitis A, B or other
___High Blood Pressure	___Herpes
___Low Blood Pressure	___Kidney problems
___Nervous Problems	___Panic attacks
___Radiation Treatment	___Rheumatic fever
___Sleep Apnea	___Sinus problems

Please tell us about any **current medical condition, NOT** listed above, which may possibly affect your dental
treatment:_____
_____

Are you **allergic** to any of the following medications: (please check all that apply).

___Penicillin	___ Aspirin	___ Ibuprofen
___Clindamycin	___ Codeine	___ Acetaminophen

___Dental Anesthetics
OTHER:_____

DENTAL HISTORY

Family
Dentist_____
How long have you been a patient in that office?
_____
Reason for today's visit:

Cancellation Policy

Colorado Gum Care strives to deliver excellent dental care to all of our patients. In order to be consistent with this philosophy, we have implemented the following appointment cancellation policy:

Surgical Visits

We request that you give our office a seven day notice in the event that you need to reschedule or cancel your procedure with the dentist. This includes all treatment visits with the dentist. If you miss an appointment for the surgical visit without providing us with the proper notice, we will consider this to be a missed appointment and a $150.00 fee may be assessed to reschedule your appointment. This fee will not be applied to your rescheduled procedure.

Office visits and Cleanings

We request that you give our office at least two full business days' notice in the event that you need to reschedule or cancel your appointment with the dentist or hygienist. If you miss an appointment for the office visit without providing us with the proper notice, we will consider this to be a missed appointment and a $75.00 fee may be assessed to reschedule your appointment. This fee will not be applied to your rescheduled procedure.

As a courtesy, we do make reminder calls, texts and/or e-mails 10 days prior to your appointment. We will also contact you to confirm your appointment 3 days prior. If you do not receive your messages or we have incorrect information, the cancellation policy will still be in effect.

_____ _____

Patient or Guardian **Date**