



ANKENY SMILES
Family Dentistry with Heart

Health Information

ANKENY SMILES TAKES YOUR ORAL HEALTH VERY SERIOUSLY, BUT BEFORE WE START YOUR TREATMENT WE NEED SOME BRIEF INFORMATION ON YOUR MEDICAL HISTORY AS IT MAY AFFECT DENTAL TREATMENT.

ALL INFORMATION IS CONFIDENTIAL

Patient's Name: _____ Date of Birth: _____ Account #: _____

Reason for today's visit? _____

Work Related Injury? (mark) **Yes No** Have you been under the care of a physician? (mark) **Yes No** Have you ever been hospitalized? (mark) **Yes No**

Date of last dental x-rays?: _____ Date of last dental visit: _____

Ever had Novocain or other local anesthetic? (mark) **Yes No** Are you interested in tooth whitening? (mark) **Yes No**

If wearing dentures, age of dentures: _____ Are you interested in new dentures? (mark) **Yes No**

Are you taking or have taken Oral Bisphosphonates, e.g., FOSAMAX, ACTONEL, BONIVA, or IV Bisphosphonates, e.g., ZOMETA, AREDIA? (mark) **Yes No**

Have you taken antibiotics prior to dental procedures in the past? (mark) **Yes No**

Have you had an adverse reaction or become ill to penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication? (mark) **Yes No**

List any medications you **are allergic** to:

List any medications that you are taking including non-prescription drugs:

Do you have a history of:	Y	N		Y	N		Y	N		Y	N
Rheumatic Fever			Asthma			Thyroid Disease			Alcoholism		
Heart Murmur			Allergies or Hives			Epilepsy or Seizures			Psychiatric Treatment		
Mitral Valve Prolapse			Anemia			Fainting or Dizzy Spells			Mouth sores/growths		
Diabetes			Aspirin/Anticoagulant Therapy			Ulcers/Stomach Problems			Teeth Grinding/Clenching		
Pace Maker/Heart Surgery			Venereal Disease			Arthritis			Pain in your Jaw (TMJ)		
High Blood Pressure			HIV Positive/Aids			Latex Allergy			Any type of Implant		
Low Blood Pressure			Blood Transfusion			Sinus Problems			Any type of Transplant		
Heart Problem			Excessive Bleeding			Cancer (Type:)			Artificial Hip, Knee or Joint		
Stroke			Hepatitis (Type:)			Chemotherapy			Tuberculosis (TB)		
Lung Disease			Liver Disease			Radiation Treatment			Dialysis		
Breathing Problems			Kidney Disease			Use of Tobacco Products			Drug Addiction		

Other Disease or Illness:

Women	Y	N		Y	N
Is there a possibility of pregnancy?			Are you nursing		
Estimated Delivery Date			Are you taking any birth control prescriptions?		
NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.					

I certify that I have read and understand the above questions and acknowledge that questions have been answered to my best of knowledge Patient's

Signature _____ Date _____ Dr's. Signature _____ Date _____



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Patient Information

Please Print

Circle One: Dr/Mr/Mrs/Ms/Miss

First: _____ Middle: _____ Last: _____ Jr/Sr: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ May we contact you by Email and Text? (circle) Yes No

Patient Social Security Number: _____ Patient Date of Birth: _____ Sex:(circle) F M

Emergency Contact: _____ Phone: _____

How did you hear about Ankeny Smiles? _____

Insurance Information

Do you have Dental Insurance? (circle) Yes No

Do you have Secondary Dental Insurance? (circle) Yes No

Primary Insurance		Secondary Insurance	
Subscriber Name		Subscriber Name	
Subscriber SSN		Subscriber SSN	
Date of Birth		Date of Birth	
Relationship to Subscriber		Relationship to Subscriber	
Employer Name		Employer Name	
Insurance Company		Insurance Company	



CANCELLATION/NO SHOW POLICY

Cancellation/No Show Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly full appointment schedule.

For repeated No Shows up to (3), you may be subject to discharge of care.

If an appointment is not cancelled at least 24 hours in advance you may be charged a fifty dollar (\$50.00) fee; this will not be covered by your insurance company and must be paid before another appointment is scheduled.

Scheduled Appointments

We understand that delays can happen, however we must try to keep the other patients and doctor on time. If a patient arrives 15 minutes past their scheduled time we may have to reschedule the appointment.

I have read and understand the Cancellation/No Show Policy for Ankeny Smiles.
I agree to comply with this office policy.

Print Patient Name

Patient /Guardian Signature

Date