Welcome to our Office

Name:_____ Date:_____

Welcome to Eagle Point Dental, the office of Dr. Heather Chisholm, Dr. Riley Miller, Dr. Lucy Lu, and their dedicated staff. We are committed to helping you achieve and maintain a healthy smile. We are committed to providing you with the very best in aesthetic, functional and cosmetic dentistry using state of the art equipment and the latest in dental technology and materials.

In our comfortable, friendly clinic, we provide a wide range of general dental services including: white fillings, implants and same day crowns and veneers using E4D technology. We use digital x-rays and are committed to helping you keep your teeth for a life time with our comprehensive dental hygiene program. We also make you look your best with Botox and other Facial Rejuvenation Procedures.

Cancellation Policy

While we understand that the unexpected does occur, we ask that you give us at least 48 hours notice if you need to cancel an appointment. **If less than 24 hours notice is given a $75.00 fee may occur.**

Payment Policy

Unless prior arrangements have been made, payment is due upon completion of treatment. For some cosmetic treatments, a deposit may be required prior to the start of treatment. For your convenience, we do accept most third party dental plans. We will fill out the necessary forms on your behalf and submit them to the dental insurance carrier. We will collect the funds from the dental insurance and your portion from you at the end of each appointment. Please note that not all services may be covered by your insurance carrier. Please note that every insurance plan has its own unique "quirks", exceptions and deductibles. It is the patient's responsibility to pay for procedures not covered by their insurance plan.

Patient/Parent/Guardian Signature:_____ Date:_____

Please Print Name:_____

Dental History

The following information helps us provide you with the best possible dental care. All information is strictly private is protected by the privacy of information act and is for our records only.

What is the reason for your dental visit today? _____

_____

When was your last dental visit?_____ What was done then?

_____

I generally visit the dentist or hygienist every?

3 months 4 months 6 months 9 months 12 months Not Routinely

1. Are any of your teeth sensitive to:
   Hot Cold Sweets Biting
2. Do you have pain in any of your teeth? Yes no
3. Have you noticed any mouth odors, bad breath or bad tastes? Yes no
4. Do you get cold sores, blisters or ulcers in your mouth or on your lips? Yes no
5. How often do you brush your teeth? _____
6. How often do you floss your teeth? _____
7. Do your gums bleed when you brush? Yes no
8. Have you noticed any loose teeth? Yes no
9. Do you have many headaches? Yes no
10. Do you clench or grind your teeth? Yes no
11. Is there anything about the appearance of your smile that you would like to change? _____

_____

_____

12. Eagle Point Dental provides a variety of cosmetic services in our full service dental clinic. Please ask us if you are interested in any of these procedures.

    Cosmetic Botox Teeth Whitening

13. How did you hear about our office? (ie. radio ad, Google search, word of mouth, etc.)

_____

Medical History

Name: _____ Birthdate: _____

Address: _____ Phone Number: _____

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private and is protected by the *Personal Information Protection Act* and is for our records only.

In case of an emergency, we should notify:

Name: _____ Relationship: _____ Phone number: _____

Physician's name: _____ Phone number: _____

1. Are you being treated for any medical condition at the present or in the past two years? If so, why?
   Yes No Not sure
   _____
2. When was your last medical check-up?
   _____
3. Has there been any change in your general health in the past year? If yes please explain.
   Yes No Not sure
   _____
4. Are you taking any medications? Please list:
   a. Prescription Medications:
      _____
      _____
   b. Over the counter medications, supplements or herbs
      _____
      _____
5. Do you have allergies? If yes please list using the categories below: Yes No Not Sure
   c. Medications_____
   d. Latex/rubber products_____
   e. Environmental (hayfever, scents) _____
   f. Food _____
6. Have you ever had a bad reaction to any medicines or injections? If yes, please explain.
   Yes No Not Sure
   _____
7. Do you have or have you ever had asthma, COPD, or other lung disease?
   Yes No Not Sure
   _____
8. Do you have or have you ever had any heart or blood pressure problems?
   Yes No Not Sure
   _____

9. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (infective endocarditis), a heart condition from birth, or a heart transplant?

Yes No Not Sure

_____

10. Do you have a prosthetic or artificial joint?

Yes No Not Sure

_____

11. Do you have any conditions or therapies that could affect your immune system e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?

Yes No Not Sure

_____

12. Have you ever had hepatitis, jaundice, or liver disease?

Yes No Not Sure

_____

13. Do you have a bleeding problem or bleeding disorder?

Yes No Not Sure

_____

14. Are you taking any medications for osteoporosis e.g. Fosamax, Actonel?

Yes No Not Sure

_____

15. Have you ever been hospitalized for any illness or operations?

Yes No Not Sure

_____

16. Do you have or have you ever had any of the following? Please Check:

Arthritis	Cancer	Chest pain	Cold sores (Herpes)
Diabetes	Drug/alcohol dependency	Heart attack	HPV (human papilloma virus)
Kidney disease	Pacemaker	Psychiatric disorder	Seizures
Shortness of breath	Sinus problems	Steroid therapy	Stomach ulcers
Stroke	Thyroid disease		

17. Do you have any other conditions or problems not listed above?

Yes No Not Sure

_____

18. Do you smoke or use other tobacco products? If yes, how much?

Yes No Not Sure

_____

19. Women: are you pregnant or trying to become pregnant?

Yes No Not Sure

_____

To the best of my knowledge, the above information is correct:

Patient/Parent/Guardian Signature: _____ Date: _____

Please Print Name: _____