Adult Health / Dental History Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Patient's Name: SSN or PT ID: Date of Birth:

Address: PO Box or Mailing Address City State Zip Code

Occupation: Height: Weight:

Phone: ( ) Home ( ) Work Emergency Contact Sex: M ☐ F ☐ Non binary ☐

Are you completing this form for another person? ☐ Yes ☐ No If yes, name? If yes, relationship?

Do you have any of the following diseases or problems: **(check DK if you don't know the answer to the question)**

	Yes	No	DK
1. Active Tuberculosis?	☐	☐	☐
2. Persistent cough greater than a three-week duration?	☐	☐	☐
3. Cough that produces blood?	☐	☐	☐
4. Exposed to anyone with Tuberculosis?	☐	☐	☐

If you answer yes to any of the four items above, please STOP and return this form to the receptionist.

Please list the name and phone number of your physician: Physician _____ Phone _____-_____-_____

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Allergies - Are you allergic to or have you had a reaction to:

	Yes	No	DK		Yes	No	DK		Yes	No	DK
Animals	☐	☐	☐	Food	☐	☐	☐	Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐	Hay fever/seasonal	☐	☐	☐	Penicillin or other antibiotics	☐	☐	☐
Barbiturates/sedative/sleeping pills	☐	☐	☐	Iodine	☐	☐	☐	Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐	Latex (rubber)	☐	☐	☐	Other:	☐	☐	☐

If Yes or other, please explain: _____

Medications: *Yes No DK*

Are you taking, or have you recently taken any prescription or over the counter medicine(s)? If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: ☐ ☐ ☐

_____

_____

Health History: *Yes No DK*

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip knee, elbow, finger) replacement? If yes, Date: _____ Any complications?_____	☐	☐	☐
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease, Multiple Myeloma, or Cancer?	☐	☐	☐

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)? If so, how interested are you in stopping? Circle one .**VERY / SOMEWHAT / NOT INTERESTED**	☐	☐	☐
Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the last 24 hours?_____	☐	☐	☐

Health History: (continued):

	Yes	No	DK
Are you in good health?	☐	☐	☐
Are you now under the care of a physician? Physician Name:_____ Phone Number:_____ Address:_____	☐	☐	☐
Has there been any change in your general health within the past year? If yes, what condition is being treated? _____	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? *Date Treatment began:* _____	☐	☐	☐

	Yes	No	DK
Have you had a serious illness, operation, or been hospitalized in the past 5 years?	☐	☐	☐
If yes, what was the illness or problem? _____ _____ _____	☐	☐	☐
Date of last physical exam:_____	☐	☐	☐
WOMEN ONLY **Are you:** Pregnant? Number of weeks?_____	☐	☐	☐
Taking birth control or hormone replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Health History: *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐
Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.			

	Yes	No	DK
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date:_____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus	☐	☐	☐
Erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Chronic pain	☐	☐	☐

	Yes	No	DK
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/ persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting or Dizziness	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
If yes, specify: _____			
Recurrent Infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐

	Yes	No	DK
Persistent swollen glands in neck	☐	☐	☐
Severe headaches or migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted Disease	☐	☐	☐
Excessive urination	☐	☐	☐
Swollen Ankles	☐	☐	☐
Shortness of Breath	☐	☐	☐
Bleeding Problems	☐	☐	☐
Difficulty Swallowing	☐	☐	☐
Diarrhea/Constipation /Blood in stool	☐	☐	☐
Vomiting /Nausea	☐	☐	☐
Difficulty Urinating	☐	☐	☐
Ringing in the Ears	☐	☐	☐
Blurred Vision	☐	☐	☐
Skin Disease	☐	☐	☐
Seizures	☐	☐	☐

	Yes	No	DK
Family History Problems? _____ _____	☐	☐	☐
Do you have any disease, condition, or problem not listed above that you think I should know about? _____ _____	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐
Name of physician or dentist making recommendation: _____ Phone : (_____)_____-_____			

What is the reason for your dental visit today? _____

How do you feel about your smile? _____

How often do you brush your teeth? _____ How often do you floss? _____

How often do you visit the dentist? _____ Date of your last dental exam: _____

Name of former Dentist? _____ Date of last dental x-rays: _____

Dental History:	*Yes*	*No*	*DK*		*Yes*	*No*	*DK*
Do your gums bleed when you brush or floss?	☐	☐	☐	Do you have earaches or neck pains?	☐	☐	☐
Do you have any loose teeth?	☐	☐	☐	Do you suffer from bad breath?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐	Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐	Do you brux or grind your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐	Do you have sores or ulcers in your mouth?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐	Do you wear dentures or partials?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐	Do you participate in active recreational activities?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐	Have you ever had a serious injury to your head or mouth?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐	Are you currently experiencing dental pain or discomfort	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐	On a scale of 1 -10 how would you rate your pain?			
If yes, how often?				☐☐☐☐☐☐☐☐☐☐			
Circle one: DAILY / WEEKLY / OCCASIONALLY				1 2 3 4 5 6 7 8 9 10			

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about 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 action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

For Completion by Dentist:

Review of Systems: (HEENT, GI, Resp, GU, MS, Endo, Skin, Neuro, Hemo)

_____

_____

_____

_____

_____

Contraindications: ☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia

_____

_____

Signature of Dentist **Reviewed by:** _____ **Date:** _____

Medical History Review:

1	Patient Signature:	Date:
	Reviewing Dentist Signature:	**Date:**
2	Patient Signature:	Date:
	Reviewing Dentist Signature:	**Date:**
3	Patient Signature:	Date:
	Reviewing Dentist Signature:	**Date:**
4	Patient Signature:	Date:
	Reviewing Dentist Signature:	**Date:**

GENERAL DENTISTRY INFORMED CONSENT

Dentist: _____ Patient: _____

1. **WORK TO BE DONE**: I understand that I am having the following work done [Indicate all services being provided]: Fillings ( ) Bridges ( ) Crowns ( ), X-rays ( ) Extractions ( ) Impacted teeth removal ( ) Root Canals ( ) Dentures ( ) Other ( ) _____.
   Patient Initials _____

2. **DRUGS AND MEDICATION:** I understand that antibiotics, analgesics and other medications may cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock. I have advised my dentist of any and all medications I am currently taking, including but not limited to prescription medications, over-the-counter medications, herbal remedies, and alternative medications. I further understand that failure to advise that failure to advise my dentist of any medications I am taking prior to starting to dental work may have unforeseen negative consequences for me.
   Patient Initials _____

3. **CHANGES IN TREATMENT PLAN:** I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discoverable during previous examinations. For example, root canal therapy may be necessary following routine restorative procedures. I give my permission to my dentist to make any/all changes and additions as necessary.
   Patient Initials _____

4. **REMOVAL OF TEETH:** Alternatives to removal have been explained to me (root canal therapy, crowns, periodontal surgery, etc.), and I authorize the dentist to remove the following teeth: _____, and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved with extraction, some of which are pain, swelling, spread of infection, dry socket, and loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time, and fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost for which is my responsibility.
   Patient Initials _____

5. **CROWNS, BRIDGES AND CAPS:** I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crowns, bridge, or cap (including shape, fit, and color) will occur only before final cementation. It is also my responsibility to return for permanent cementation within 21 days from initial tooth preparation. Excessive delays may allow for tooth movement which may necessitate a remake of the crown, bridge, or cap. In such instances, I understand that there will be additional charges for remakes due to my delaying permanent cementation.
   Patient Initials _____

6. **ENDODONTIC TREATMENT (ROOT CANAL):** I realize there is no guarantee that root canal therapy will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling material may extend through the tooth which does not necessarily affect the success of the treatment. I understand that endodontic files are very fine instruments and stresses from their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary

following root canal treatment (apicoetomy). I understand that the tooth may be lost in spite of all efforts to save it.
Patient Initials _____

7. **PERIODONTAL LOSS (TISSUE AND BONE):** I understand that if I am being treated for periodontal disease, this means I have a serious condition, causing gum and bone inflammation or loss and that it can ultimately lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that any dental procedure may have a future adverse effect on my periodontal condition.
Patient Initials _____

8. **FILLINGS:** I understand that care must be taken when chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that increased sensitivity is a common effect of a newly placed filling.
Patient Initials _____

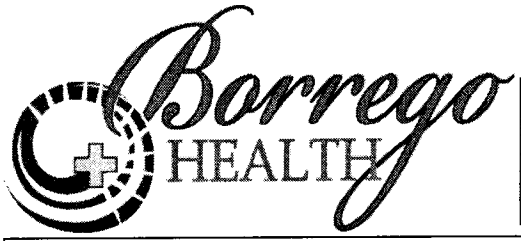
9. **DENTURES:** I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems associated with dentures. Immediate dentures (placement of denture immediately after extractions) may be painful. In addition, immediate dentures often require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delay of 30 days or more, there may be additional charges assessed against me.
Patient Initials _____

I understand that dentistry is an inexact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment(s) which I have requested and authorized.

I hereby authorize any of the doctors or dental assistants or auxiliaries to proceed with and perform the dental restorations and treatments indicated above and as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosed circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I may be responsible for payment of the dental fees.

Signature of Patient: _____ Date: _____

Signature of Dentist: _____ Date: _____



PATIENT INFORMATION

Gender: M ☐ F ☐ Social Security # DOB: Month Day Year

Name: First Middle Last

Street Address: | Apt. / Ste: | P.O. Box:

City: | State: | ZIP Code: | Home Phone:

Cell Phone: | Email: | Text Messages? Yes ☐ No ☐

RESPONSIBLE PARTY/ GUARANTOR

Name: First Middle Last | DOB: Month Day Year | Gender: M ☐ F ☐

Street Address: | City: | State: | ZIP Code:

Relation: Self ☐ Spouse ☐ Parent ☐ Child ☐ Guardian ☐ Caregiver ☐ Other:

Home Phone: | Cell Phone:

EMERGENCY CONTACT

Name: First Middle Last

Street Address: | City: | State: | ZIP Code:

Relation: Sibling ☐ Parent ☐ Grandparent ☐ Aunt/ Uncle ☐ Neighbor ☐ Friend ☐ Other:

Home Phone: | Cell Phone:

ADDITIONAL PATIENT INFORMATION

Average Household Income: $ Weekly ☐ Bi-Weekly ☐ Twice a Month ☐ Monthly ☐ Yearly ☐

Number of household members: | Housing Status: Not Homeless ☐ Homeless ☐ Shelter ☐ Other:

Primary Language: English ☐ Spanish ☐ Other: | Race: White ☐ American Indian/ Alaska Native ☐

Asian ☐ Black/ African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Refused to Report/ Unreported ☐

Ethnicity: Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refused/Unreported ☐ | Are you or is anyone in your household a:

Migrant Worker ☐ Dependent of a Migrant Worker ☐ Seasonal Migrant Worker ☐ Dependent of a Seasonal Migrant Worker ☐

Non-Agricultural Worker ☐ Refused/Unreported ☐

*A migrant worker is one who works in agriculture away from home within the last 24 months, and has temporary housing. Seasonal migrant worker is one who works part-time in agriculture, but does not live in temporary housing

PRIMARY PHYSICIAN & PHARMACY

Name: First Last | Street Address:

City: | State: | ZIP: | Phone: | Fax:

Preferred Pharmacy: | Phone: | Fax:

RESET ALL FIELDS

SIGNATURE

I certify that the information on this form is complete and correct. Date: Signature:

GENERAL CONSENT FOR MEDICAL TREATMENT

CONSENT FOR TREATMENT: The undersigned patient, responsible relative and/or patient's legal representative herby voluntarily consent and authorize such care and treatments, including but not limited to physical or mental examination, diagnostic tests, medical procedures and medications by employees and authorized agents of Borrego Health including all affiliated physicians, dentists, nurse practitioners and physician assistants, nursing staff and other ancillary providers. as may be considered necessary or advisable in their professional judgment. I, the undersigned, am aware that the practice of medicine is not an exact science and further acknowledge that no guarantees have been made regarding the effect such treatments on any medical condition.

RIGHT TO REFUSE TREATMENT: The undersigned responsible party further understands the he/she has the right to make informed decisions regarding all care and treatments, and that he/she may ask the health care professional to explain anything that is not understood. This right includes the right to refuse any treatments by advising their clinician.

TEACHING PROGRAMS: Borrego Health participates/contracts with training institutions for teaching medical students, interns, residents, healing arts students (i.e.: nursing, hygienists, x-ray technicians, dental assistants) and post graduate students. I understand that these trainees may participate in the care provided under the supervision of a qualified and/or licensed personnel.

RELEASE OF INFORMATION: I hereby authorize Borrego Health employees and affiliates to release such medical information from my medical records as is necessary to complete forms for continued care, payment by insurance carriers, health care plans and third party payors including employers, health service plans or worker's compensation carriers.

_____ I, the undersigned, acknowledge having received a **Notice of Privacy Practices** which outlines which health information may be used or disclosed.

_____ I, the undersigned, consent to such disclosures as delineated in the Notice and understand that this may include information related to HIV/AIDS, behavioral health services and treatment for alcohol and/or drug abuse.

ASSIGNMENT OF HEALTH BENEFITS: I, the undersigned, hereby authorize and instruct the insurance carrier to make payment directly to Borrego Community Health Foundation for any medical, dental or vision benefits otherwise payable to me or my guarantor as payment toward the total charges for professional services rendered. I understand that insurance co-payments, co-insurance and non-covered services are my or may guarantor's financial responsibility.

FINANCIAL AGREEMENT: I, the undersigned, agree to pay, whether signing as a patient or representative of the patient, the charges incurred at Borrego Health in keeping with the established fee schedule. I understand that if I am a member of a Health Maintenance Organization (HMO) and have not secured authorization for payment of services, I will be held financially responsible for all non-covered services. I also understand that I am responsible for any balance owed and that a cash deposit will be required for patients not otherwise approved for the sliding fee discount program or other public benefits.

ADVANCE DIRECTIVES: Adults 18 and older have the right (a) to give direction about their future medical care or (b) to designate a patient representative to make medical decisions for them if they lose individual decision-making capacity. I, the undersigned, understand that information about advance directives is available to me upon request _____I would like further information.

_____I do not want additional information now, but can request information at a later time.

Patient Name:_____

Patient Representative:_____

Patient/Legal Representative Signature:_____

Witness:_____ Date:_____

AVISO DE PRÁCTICAS DE PRIVACIDAD

Acuse de Recibo

Al firmar este formulario, reconoces haber recibido la "Notificación de Practicas de Privacidad" por parte de Borrego Health. Nuestra "Notificación de Practicas de Privacidad" ofrece información acerca de cómo podríamos utilizar y divulgar tu información medica protegida. Te recomendamos leerlo completamente.

Nuestra "Notificación de Practicas de Privacidad" se halla sujeta a cambios. Si realizamos cambios en nuestra notificación, obtendrás una copia de la notificación modificada en nuestro sitio de internet, o comunicándote con el Oficial de Privacidad o con la Clínica.

Si tienes dudas acerca de nuestra "Notificación de Practicas de Privacidad", favor de comunicarte con la Oficina de Privacidad al (619) 398-2405.

Confirmo de recibida la "Notificación de Practicas de Privacidad" de Borrego Health.

Nombre del Paciente: _____ _____

Fecha de Nacimiento: _____ Número de Expediente Medico: _____

Firma: _____Fecha de firma: _____

Si firma algún alterno al paciente, indicar parentesco: _____

Nombre del Representante Legal:_____

For Office Use Only (solo para uso Oficial): Inability to Obtain Acknowledgment (Imposibilidad de Obtener la Confirmacion)

The patient listed above received a copy of, and had an opportunity to review, the Notice of Privacy Practices. We attempted to obtain written acknowledgement of receipt of the Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign
☐ Communication barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other (Please Specify) _____

Employee Name: _____ Date: _____

Employee Signature: _____

Broken Appointment policy notice

We have more patients who need dental care than we have room in our daily schedule to provide. When a patient does not show up for their appointment or cancels too close to their scheduled time, we are unable to fill this appointment time with another patient who desperately needs dental care. This policy is our attempt to ensure that both you and our other patients receive the dental care that you need.

Broken Appointments: Patients are only allowed THREE broken appointment in a 12 month time period.

- Broken appointments are any time you are scheduled for an appointment and you do not show for that appointment.

- Late cancelations are considered broken appointments. If you need to cancel your appointment, we ask that you please call us at least 24 hours before your appointment time.

- Late arrivals are also considered broken appointments. If you do not arrive by 10 minutes after the start time of your appointment, it will be given to another patient.

If for any reason, a patient misses their appointment or cancels late for a FOURTH time within a 12 month period, they will not be scheduled for another appointment due to patient-doctor relationship has Ended. However, these patients are still welcome to receive their dental care from us on emergency only. Patients can either call us in the morning for a "same day appointment," or they may come to our clinic as a "walk-in patient." We always do our best to work our walk-in patients into the schedule as long as it does not interfere with the care of previously scheduled patients; but please understand there is no guarantee that you will receive an appointment as a "same day appointment" or "walk-in."

Patient Signature _____ Date_____

Missing or canceling appointment policy

We value you as our patient and need your cooperation with keeping appointments so that we can provide your care. Missing or late canceling an appointment means we are unable to fill this appointment time with another patient who desperately needs care. Our policy requires:

• Timely Cancellations: If you need to cancel or reschedule your appointment, you must give us at least 24 hours' notice. Cancellations made with less than 24 hours' notice will be considered a missed appointment.

Initials _____

• On Time Arrivals: If you are more than 10 minutes late to your appointment, we will give your appointment away to another patient. This will be considered a missed appointment.

Initials_____

• Compliance: Patients are only allowed THREE missed appointment in a 12 month period. After the FOURTH missed appointment, you will not be scheduled appointments, but are welcome to use our clinic as a "walk-in" patient.

Initials_____

Your help in keeping your appointments enables us to provide better and timelier care for all our patients.

Signing below certifies, I the patient or guardian have been notified and understand the Broken appointment policy and agree to the terms.

Patient or Parent/Guardian Signature _____

Date _____