Welcome to our practice!

Thank you for selecting us for your dental care.

We are committed to providing you with the highest quality dental care, whether that is through relieving pain, preventing dental problems, brightening your smile, or simply building a relationship with our staff. Our team is eager to make you feel comfortable, informed, and appreciated.

So let's get started. Please take a few minutes to fill out this form on your desktop or by hand. This form is sectioned into four parts:

- **Part I: General Patient Information – Pages 2-3**
- **Part II: Financial Policy – Pages 4**
- **Part III: Notice of Privacy Practices Consent – Page 5**
- **Part IV: Patient Health History – Pages 6-12**

Questions? We encourage you to contact us if you have any questions prior to your appointment – *we will be happy to help.*

Upon completing your paperwork, please attach and email it back to us at ashlanddentalhealth@gmail.com or bring it with you to your first appointment.

Thank you again for choosing our office as your dental health care provider. We look forward to meeting you as well as taking care of your dental needs!

Sincerely,

Dr. Brian J. Kitchell DMD

Dr. Aaron J. Omura DMD MDS

Please remember to bring or send us your form. Thanks!

Dr. Brian J. Kitchell DMD
Dr. Aaron J. Omura DMD MDS

277 5th Street
Ashland, Oregon 97520

T 541.482.1744
F 541.482.4128

PART I: Patient Information Form

To help us meet all your healthcare needs, please complete the following information. If you have questions or need our assistance, please contact us – *we will be happy to help.*

HOW WOULD YOU LIKE TO BE NOTIFIED FOR FUTURE APPOINTMENTS? ☐ PHONE CALL ☐ TEXT MESSAGE ☐ BOTH

PATIENT INFORMATION

PATIENT'S NAME (FIRST, MIDDLE INITIAL, LAST)

TODAY'S DATE (MM-DD-YYYY)

DATE OF BIRTH (MM-DD-YYYY)

EMAIL ADDRESS

MAILING (STREET) ADDRESS

CITY, STATE, ZIP CODE

MAIN PHONE (XXX) XXX-XXXX ☐ HOME ☐ WORK ☐ CELL

ALTERNATE PHONE (XXX) XXX-XXXX ☐ HOME ☐ WORK ☐ CELL

OCCUPATION

EMPLOYER

CHECK APPROPRIATE BOX ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

GENDER IDENTIFICATION ☐ MALE ☐ FEMALE ☐ OTHER _____

HOW WOULD YOU LIKE TO BE ADDRESSED? ☐ HE/HIM ☐ SHE/HER ☐ THEY/THEM

PERSON TO CONTACT IN CASE OF EMERGENCY

CONTACT'S PHONE (XXX) XXX-XXXX ☐ HOME ☐ WORK ☐ CELL

HOW DID YOU HEAR ABOUT US? ☐ FAMILY/FRIEND ☐ PHYSICIAN/DENTIST ☐ INTERNET ☐ ADVERTISEMENT ☐ OTHER _____

IF REFERRED BY SOMEONE, WHOM MAY WE THANK FOR THE REFERRAL? _____

RESPONSIBLE PARTY FOR THIS ACCOUNT IF OTHER THAN PATIENT

IF PATIENT IS ☐ RESPONSIBLE PARTY (CHECK BOX). THEN LEAVE THIS SECTION BLANK AND CONTINUE TO THE NEXT PAGE.

NAME OF RESPONSIBLE PARTY (FIRST, MIDDLE INITIAL, LAST)

DATE OF BIRTH (MM-DD-YYYY)

EMAIL ADDRESS

RELATIONSHIP TO PATIENT

MAILING (STREET) ADDRESS

CITY, STATE, ZIP CODE

MAIN PHONE (XXX) XXX-XXXX ☐ HOME ☐ WORK ☐ CELL

ALTERNATE PHONE (XXX) XXX-XXXX ☐ HOME ☐ WORK ☐ CELL

OCCUPATION

EMPLOYER

(continued on next page)

NOTE: OUR FINANCIAL POLICY MUST BE REVIEWED AND SIGNED BY RESPONSIBLE PARTY/GUARANTOR. SEE PAGE 4.

PRIMARY DENTAL INSURANCE INFORMATION

NOTE: Please remember to bring your insurance card(s) so that we can take a photo copy for our records.

NAME OF DENTAL INSURANCE COMPANY

GROUP NUMBER

POLICYHOLDER'S NAME (FIRST, MIDDLE INITIAL, LAST)

POLICYHOLDER'S ID NUMBER

POLICYHOLDER'S DATE OF BIRTH (MM-DD-YYYY)

POLICYHOLDER'S EMPLOYER

POLICYHOLDER'S EMAIL ADDRESS

POLICYHOLDER'S PHONE (XXX) XXX-XXXX ☐ HOME ☐ WORK ☐ CELL

DENTAL INSURANCE COMPANY'S MAILING (STREET) ADDRESS

CITY, STATE, ZIP CODE

SECONDARY DENTAL INSURANCE INFORMATION

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐ YES ☐ NO (IF YES, PLEASE COMPLETE THE FOLLOWING)

NAME OF DENTAL INSURANCE COMPANY

GROUP NUMBER

POLICYHOLDER'S NAME (FIRST, MIDDLE INITIAL, LAST)

POLICYHOLDER'S ID NUMBER

POLICYHOLDER'S DATE OF BIRTH (MM-DD-YYYY)

POLICYHOLDER'S EMPLOYER

POLICYHOLDER'S EMAIL ADDRESS

POLICYHOLDER'S PHONE (XXX) XXX-XXXX ☐ HOME ☐ WORK ☐ CELL

DENTAL INSURANCE COMPANY'S MAILING (STREET) ADDRESS

CITY, STATE, ZIP CODE

AUTHORIZATION

- I certify that I have read and understand the above information to the best of my knowledge.
- I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.
- I understand that my dental insurance carrier may pay less than the actual bill for services.
- I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X

SIGNATURE
Patient, Patient Representative, or Parent/Legal Guardian if Minor

TODAY'S DATE (MM-DD-YYYY)

PRINT NAME OF SIGNEE (FIRST, MIDDLE INITIAL, LAST)

If signed by Patient Representative, STATE RELATIONSHIP TO PATIENT

☐ I APPROVE MY DIGITALLY-SIGNED SIGNATURE ABOVE.

*Please proceed to **Part II** on the next page. >*

PART II: Financial Policy

This agreement is to inform you of your financial obligation to our practice. If you have any questions or need assistance, please contact us – *we will be happy to help.*

TERMS & CONDITIONS

- *Payment is required at the time of service* unless prior arrangements have been made.
- We accept cash, checks, money orders, VISA® or MasterCard.® Payment plans may be setup through CareCredit.®
- If you have insurance, it is your responsibility to contact your insurance carrier to find out what portion of the fees will be covered by your plan. A 5% service charge for the total cost of service will be applied if the "patient responsible" portion is not paid on the day of service.
- If you do not have insurance we offer a 10% senior discount for patients 65 and older when payment is made on the day of service. For those under 65 we offer a 5% discount when payment is made by cash or check.
- Insurance billing will be done for you as a courtesy. We must emphasize that our relationship is with you and not with your insurance company. Insurance companies use the term "Usual and Customary" when setting fee limitations for individual policy contracts. The term suggests, but does not necessarily reflect the average fees charged by dentists in your community. Please be aware that some insurance companies will pay a claim percentage based on "their" usual and customary, and not the actual charges. Therefore, the difference is your responsibility.
- Returned checks will be assessed a **$25.00** NSF (Non-Sufficient Funds) fee. We will require you pay this charge as allowed by Oregon law in order to clear your record with our office. Partial payments are not acceptable on returned checks.
- Except in emergency situations, you can expect us to be on time for you. We would appreciate the same courtesy. If for some reason you are unable to keep your appointment and need to cancel, please notify us **24 hours** in advance. A **$75-$200 per hour** charge may be made if you fail to show up for any appts.
- If this agreement is placed in the hands of a collection agency or an attorney for collection, the non-prevailing party agrees to pay reasonable attorney's fees and costs as set by the court having jurisdiction, including cost in any appellate court.

AUTHORIZATION

- I have read the financial policy.
- I understand and accept the financial and the dental insurance policies listed and have had any and all questions answered to my satisfaction.
- I agree to pay for all treatment as described so as to avoid any additional fees.

X _____

SIGNATURE
Patient, Patient Representative, or Parent/Legal Guardian if Minor

_____

TODAY'S DATE (MM-DD-YYYY)

_____

PRINT NAME OF SIGNEE (FIRST, MIDDLE INITIAL, LAST)

_____

If signed by Patient Representative, STATE RELATIONSHIP TO PATIENT

☐ I APPROVE MY DIGITALLY-SIGNED SIGNATURE ABOVE.

*Please proceed to **Part III** on the next page. >*

PART III: Notice of Privacy Practices Consent

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. If you have questions or need our assistance, please contact us – *we will be happy to help.*

CONSENT & AUTHORIZATION

- I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operation like quality reviews.
- I have been informed that I may review the practice/clinic's *Notice of Privacy Practices* (for a more complete description of uses and disclosures) before signing this consent.
- I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.
- I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction, they must follow the restriction(s).
- I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

X _____

SIGNATURE
Patient, Patient Representative, or Parent/Legal Guardian if Minor

_____

TODAY'S DATE (MM-DD-YYYY)

_____

PRINT NAME OF SIGNEE (FIRST, MIDDLE INITIAL, LAST)

_____

If signed by Patient Representative, STATE RELATIONSHIP TO PATIENT

☐ I APPROVE MY DIGITALLY-SIGNED SIGNATURE ABOVE.

FOR OFFICE USE ONLY

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency prevented us from obtaining acknowledgement

☐ Other *(please specify)* _____

_____

PATIENT'S NAME (FIRST, MIDDLE INITIAL, LAST)

_____

ACCOUNT NUMBER

*Please proceed to **Part IV** on the next page. >*

PART IV: Patient Health History

The following information is vital to allow us to provide the best possible care for you. Your answers are for our records only and will be kept confidential subject to applicable laws. If you have questions or need our assistance, please contact us – *we will be happy to help.*

PATIENT'S NAME (FIRST, MIDDLE INITIAL, LAST)

DATE OF BIRTH (MM-DD-YYYY)

PREVIOUS DENTIST'S NAME (FIRST, LAST)

CURRENT PHYSICIAN'S NAME (FIRST, LAST))

DATE OF LAST DENTAL EXAM AND/OR DENTAL X-RAYS (MM-YYYY)

DATE OF LAST MEDICAL EXAM (MM-YYYY)

WHAT WAS DONE AT YOUR LAST DENTAL APPOINTMENT?

WHAT WAS DONE AT YOUR LAST MEDICAL APPOINTMENT?

If necessary, is there someone we can speak to regarding your dental care? *List below:*

NAME (FIRST, MIDDLE INITIAL, LAST)

PHONE (XXX) XXX-XXXX ☐ HOME ☐ WORK ☐ CELL

RELATIONSHIP TO PATIENT

If you are completing this form for this patient, please complete the following:

YOUR NAME (FIRST, MIDDLE INITIAL, LAST)

YOUR RELATIONSHIP TO PATIENT

YOUR EMAIL ADDRESS

YOUR PHONE (XXX) XXX-XXXX ☐ HOME ☐ WORK ☐ CELL

Please answer "YES" or "NO" by marking a (■) for the following questions, or as applicable. **Throughout this questionnaire, if you don't know the answer or don't understand the question, *please leave it blank.***

	DO YOU HAVE ANY OF THE FOLLOWING DISEASES OR PROBLEMS	
1	☐ Yes ☐ No	Active Tuberculosis?
2	☐ Yes ☐ No	Been exposed to anyone with Tuberculosis?
3	☐ Yes ☐ No	Persistent cough or throat clearing not associated with a known illness, lasting more than a 3 week duration?
4	☐ Yes ☐ No	Cough that produces blood?
5	☐ Yes ☐ No	Coronavirus (COVID-19)?
6	☐ Yes ☐ No	Been exposed to anyone with Coronavirus (COVID-19)?
7	☐ Yes ☐ No	Symptoms including: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea?

If you answer "YES" to any of these items above, please stop and contact our office. We will advise you on how we will proceed with your appointment. *Thank you.*

(continued on next page)

Dental History

Please answer "YES" or "NO" by marking a (■) for the following questions, or as applicable.
If you don't know the answer or don't understand the question, *please leave it blank.*

YOUR DENTAL HEALTH		
8	☐ Yes ☐ No	Is there a reason for your dental visit today? Do you have any immediate concerns?
9	☐ Yes ☐ No	Is there anything about the appearance of your teeth you would like to change?
10	☐ Yes ☐ No	Are you currently experiencing dental pain or discomfort?
11	☐ Yes ☐ No	Are you fearful of dental treatments? *How fearful on a scale of 1 (least) to 10 (most)?*
12	☐ Yes ☐ No	Have you had an upsetting dental experience?
13	☐ Yes ☐ No	Have you had any complications from past dental treatment(s)?
14	☐ Yes ☐ No	Do you routinely see the dentist? *If so, every:* ☐ 3 MONTHS ☐ 4 MONTHS ☐ 6 MONTHS ☐ 12 MONTHS
15	☐ Yes ☐ No	Have you had any cavities within the past 3 years?
16	☐ Yes ☐ No	Do you brush and floss your teeth daily? *How many times a day?*
17	☐ Yes ☐ No	Do you frequently get food or floss caught between any teeth?
18	☐ Yes ☐ No	Does the amount of saliva in your mouth seem too little or do you have any difficulties swallowing any food?
19	☐ Yes ☐ No	Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?
20	☐ Yes ☐ No	Are any of your teeth sensitive to cold, hot, sweets or pressure?
21	☐ Yes ☐ No	Do you avoid brushing or cleaning any part of your mouth?
22	☐ Yes ☐ No	Do you have any grooves or notches on your teeth near the gum line?
23	☐ Yes ☐ No	Have you ever had broken teeth, chipped teeth, or had a toothache, or cracked filling?
24	☐ Yes ☐ No	Have you ever had trouble getting numb or had any reactions to local anesthetic?
25	☐ Yes ☐ No	Did you ever have braces, or orthodontic treatment?
26	☐ Yes ☐ No	Do you participate in active recreational activities?
27	☐ Yes ☐ No	Have you ever had a serious injury to your head, neck, or mouth?
28	☐ Yes ☐ No	Have you had any teeth removed?
29	☐ Yes ☐ No	Do your gums bleed or are they painful when brushing or flossing?
30	☐ Yes ☐ No	Have you ever noticed gum recession?
31	☐ Yes ☐ No	Have you ever been told you have lost bone around your teeth?
32	☐ Yes ☐ No	Have you had any periodontal (gum) treatments?
33	☐ Yes ☐ No	Is there anyone with a history of periodontal disease or tooth loss in your family?
34	☐ Yes ☐ No	Do you frequently get cold sores, blisters, ulcers, or other oral lesions in your mouth?
35	☐ Yes ☐ No	Have you ever noticed an unpleasant odor or bad taste in your mouth?
36	☐ Yes ☐ No	Do you have acid reflux/persistent heartburn?
37	☐ Yes ☐ No	Have you had any teeth become loose on their own (no injury), or a change in your bite?
38	☐ Yes ☐ No	Have you experienced a burning sensation in your mouth?

(continued on next page)

YOUR DENTAL HEALTH *(continued)*		
39	☐ Yes ☐ No	Do you wear dentures or partials?
40	☐ Yes ☐ No	Do you have any crowns, veneers, bridges, or any other oral restorations?
41	☐ Yes ☐ No	Have you ever had oral surgery (i.e. wisdom teeth extraction)?
42	☐ Yes ☐ No	Do you have frequent headaches?
43	☐ Yes ☐ No	Do you have any memory loss issues?
44	☐ Yes ☐ No	Do you or have you been told you snore?
45	☐ Yes ☐ No	Have you ever been diagnosed with sleep apnea or any other sleeping disorders?

YOUR BITE & JAW JOINT		
46	☐ Yes ☐ No	Do you have earaches, neck aches or shoulder aches?
47	☐ Yes ☐ No	Have you ever experienced any of the following problems in your jaw joint? • Popping, clicking, locking; • Pain, discomfort (joint, ear, side of face); • Difficulty in opening or closing, or chewing on either side of your mouth.
48	☐ Yes ☐ No	Do you have any problems chewing gum, bagels, protein bars, or other hard foods?
49	☐ Yes ☐ No	Have your teeth changed in the last 5 years, become shorter, thinner, or worn?
50	☐ Yes ☐ No	Are your teeth crowding or developing spaces?
51	☐ Yes ☐ No	Do you have to squeeze to make your teeth fit together?
52	☐ Yes ☐ No	Do you chew ice, bite your nails, use your teeth to hold objects, or have other oral habits?
53	☐ Yes ☐ No	Do you clench or grind your teeth while awake or asleep?
54	☐ Yes ☐ No	Do you breathe through your mouth while awake or asleep?
55	☐ Yes ☐ No	Do you have tired/sore jaws, especially in the morning?
56	☐ Yes ☐ No	Do you wear or have you ever worn a bite plate or mouth guard?
57	☐ Yes ☐ No	Have you ever had your teeth ground or the bite adjusted?

YOUR SMILE		
58	☐ Yes ☐ No	Have you felt uncomfortable or self-conscious about the appearance of your teeth?
59	☐ Yes ☐ No	Have you ever whitened (bleached) your teeth?
60	☐ Yes ☐ No	Have you been disappointed with the appearance of previous dental work?

ALL PATIENTS		
61	☐ Yes ☐ No	Do you have or have you had any other dental conditions or problems NOT listed above that you think should be addressed? *If so, please explain:*
62	☐ Yes ☐ No	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

(continued on next page)

Medical History

Although your 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 relationship with the dentistry you will receive.

Please answer "YES" or "NO" by marking a (■) for the following questions, or as applicable.
If you don't know the answer or don't understand the question, *please leave it blank.*

YOUR MEDICAL HEALTH		
1	☐ Yes ☐ No	Are you in good health?
2	☐ Yes ☐ No	Has there been any changes in your general health within the past year? *If YES, what condition is being treated?*
3	☐ Yes ☐ No	Have you had a serious illness, operation or been hospitalized in the past 5 years? *If YES, what was the illness or problem?*
4	☐ Yes ☐ No	Are you now under the care of a physician?

DO YOU HAVE, OR HAVE YOU HAD		
5	☐ Yes ☐ No	Chest pain (Angina)?
6	☐ Yes ☐ No	Recent (severe or rapid) weight loss, fever, night sweats?
7	☐ Yes ☐ No	Sinus problems?
8	☐ Yes ☐ No	Severe headaches/migraines?
9	☐ Yes ☐ No	Heart disease?
10	☐ Yes ☐ No	Heart attack, heart defects?
11	☐ Yes ☐ No	Stroke, hardening of arteries?
12	☐ Yes ☐ No	High blood pressure?
13	☐ Yes ☐ No	Low blood pressure?
14	☐ Yes ☐ No	Congestive heart failure?
15	☐ Yes ☐ No	Damaged heart valves?
16	☐ Yes ☐ No	Heart murmurs?
17	☐ Yes ☐ No	Other congenital heart defects?
18	☐ Yes ☐ No	Mitral valve prolapse?
19	☐ Yes ☐ No	Artificial (Prosthetic) heart valve?
20	☐ Yes ☐ No	Pacemaker? Defibrillator?
21	☐ Yes ☐ No	Rheumatic fever?
22	☐ Yes ☐ No	Rheumatic heart disease?
23	☐ Yes ☐ No	Arteriosclerosis?
24	☐ Yes ☐ No	Asthma, Emphysema, Bronchitis, other lung diseases?
25	☐ Yes ☐ No	Hepatitis, jaundice, other liver disease?
26	☐ Yes ☐ No	Thyroid, adrenal disease?
27	☐ Yes ☐ No	Cancer, tumors?
28	☐ Yes ☐ No	Chemotherapy, radiation treatments?
29	☐ Yes ☐ No	Diabetes (Type I or II)?
30	☐ Yes ☐ No	Family history of diabetes, heart problems, tumors?
31	☐ Yes ☐ No	Abnormal bleeding, bruising easily?
32	☐ Yes ☐ No	Anemia?
33	☐ Yes ☐ No	Blood transfusion? *If YES, list date:*
34	☐ Yes ☐ No	Hemophilia?
35	☐ Yes ☐ No	Hospitalization?
36	☐ Yes ☐ No	Surgeries?
37	☐ Yes ☐ No	Mental health disorders? *If YES, specify:*
38	☐ Yes ☐ No	Psychiatric care?
39	☐ Yes ☐ No	Neurological disorders? *If YES, specify:*
40	☐ Yes ☐ No	Artificial joint replacement, implant, prothesis?
41	☐ Yes ☐ No	Arthritis?
42	☐ Yes ☐ No	Autoimmune disease?
43	☐ Yes ☐ No	Rheumatoid arthritis?
44	☐ Yes ☐ No	Swollen ankles?
45	☐ Yes ☐ No	Systemic lupus erythematosus?
46	☐ Yes ☐ No	Shortness of breath?

(continued on next page)

DO YOU HAVE, OR HAVE YOU HAD *(continued)*					
47	☐ Yes ☐ No	Ringing in ears?	59	☐ Yes ☐ No	Fainting spells or seizures?
48	☐ Yes ☐ No	Blurred vision?	60	☐ Yes ☐ No	Osteoporosis?
49	☐ Yes ☐ No	Eye disease (e.g. Glaucoma, Cataract)?	61	☐ Yes ☐ No	Persistent swollen glands in neck?
50	☐ Yes ☐ No	Tonsillitis?	62	☐ Yes ☐ No	Recurrent infections? *If YES, specify:*
51	☐ Yes ☐ No	Chest pain upon exertion?	63	☐ Yes ☐ No	Excessive thirst?
52	☐ Yes ☐ No	Chronic pain?	64	☐ Yes ☐ No	Frequent/excessive urination?
53	☐ Yes ☐ No	Eating disorders?	65	☐ Yes ☐ No	Frequent vomiting, nausea?
54	☐ Yes ☐ No	Malnutrition?	66	☐ Yes ☐ No	AIDS/HIV?
55	☐ Yes ☐ No	Stomach problems, ulcers?	67	☐ Yes ☐ No	Sexually transmitted diseases (STDs)?
56	☐ Yes ☐ No	Gastrointestinal disease?	68	☐ Yes ☐ No	Herpes?
57	☐ Yes ☐ No	Kidney, bladder disease?	69	☐ Yes ☐ No	Contact lenses?
58	☐ Yes ☐ No	Epilepsy/convulsions?			

ARE YOU TAKING		
70	☐ Yes ☐ No	Any medication containing Bisphosphonates (Osteoporosis/cancer medications)?
71	☐ Yes ☐ No	Prescription drugs, medications, over-the-counter medicines, natural remedies?
If so, list all current medications (including vitamins, natural or herbal preparations, and/or diet supplements) and what they are used to treat:		
72	☐ Yes ☐ No	Do you use controlled substances (recreational drugs)?
73	☐ Yes ☐ No	Do you use tobacco in any form (smoking, vaping, snuff, chew, etc)?
74	☐ Yes ☐ No	Do you drink alcoholic beverages?

ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO		
To all "YES" responses, *please specify type of reaction.*		
75	☐ Yes ☐ No	Local anesthetics?
76	☐ Yes ☐ No	Aspirin?
77	☐ Yes ☐ No	Penicillin or other antibiotics?
78	☐ Yes ☐ No	Barbiturates, sedatives, or sleeping pills?
79	☐ Yes ☐ No	Sulfa drugs?
80	☐ Yes ☐ No	Codeine or other narcotics?
81	☐ Yes ☐ No	Metals?
82	☐ Yes ☐ No	Latex (rubber)?
83	☐ Yes ☐ No	Iodine?
84	☐ Yes ☐ No	Other? *List here:*

(continued on next page)

WOMEN ONLY		
85	☐ Yes ☐ No	Are you pregnant or think you may be pregnant? *Number of weeks:*
86	☐ Yes ☐ No	Are you nursing?
87	☐ Yes ☐ No	Are you taking birth control pills (oral contraceptives) or hormonal replacement therapy?

ALL PATIENTS		
88	☐ Yes ☐ No	Do you have or have you had any other diseases, conditions or medical problems NOT listed above that you think should be addressed? *If so, please explain:*

AUTHORIZATION

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

- I certify that I have read and understand the above information to the best of my knowledge.
- I understand the importance of a truthful health history and that my dentist and staff will rely on this information for treating me and that providing incorrect information can be dangerous to my health. The above questions have been accurately answered.
- I will inform my dentist of any change in my health and/or medication.
- I authorize my dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such dental care to third party payors and/or health practitioners.
- 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 staff members, 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.

X _____

SIGNATURE
Patient, Patient Representative, or Parent/Legal Guardian if Minor

TODAY'S DATE (MM-DD-YYYY)

PRINT NAME OF SIGNEE (FIRST, MIDDLE INITIAL, LAST)

If signed by Patient Representative, STATE RELATIONSHIP TO PATIENT

☐ I APPROVE MY DIGITALLY-SIGNED SIGNATURE ABOVE.

Patient's Notes:

(continued on next page)

YOUR RECALL REVIEW

X 1. PATIENT'S SIGNATURE	DATE (MM-DD-YYYY)	REVIEWED BY (INITIAL)
X 2. PATIENT'S SIGNATURE	DATE (MM-DD-YYYY)	REVIEWED BY (INITIAL)
X 3. PATIENT'S SIGNATURE	DATE (MM-DD-YYYY)	REVIEWED BY (INITIAL)
X 4. PATIENT'S SIGNATURE	DATE (MM-DD-YYYY)	REVIEWED BY (INITIAL)
X 5. PATIENT'S SIGNATURE	DATE (MM-DD-YYYY)	REVIEWED BY (INITIAL)
X 6. PATIENT'S SIGNATURE	DATE (MM-DD-YYYY)	REVIEWED BY (INITIAL)
X 7. PATIENT'S SIGNATURE	DATE (MM-DD-YYYY)	REVIEWED BY (INITIAL)
X 8. PATIENT'S SIGNATURE	DATE (MM-DD-YYYY)	REVIEWED BY (INITIAL
X 9. PATIENT'S SIGNATURE	DATE (MM-DD-YYYY)	REVIEWED BY (INITIAL)

Doctor's Comments:

X

DOCTOR'S SIGNATURE

TODAY'S DATE (MM-DD-YYYY)

Dr. Brian J. Kitchell DMD
Dr. Aaron J. Omura DMD MDS

277 5th Street
Ashland, Oregon 97520

T 541.482.1744
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