Karen Nation, D.M.D.
Patient Information

Date: _____ Height_____ Weight_____

Patient Name:_____ Preferred Name:_____
Last First MI

□ Male □ Female □ Married □ Single □ If child, parent's name _____

Birth Date:_____ Social Security #_____

Phone (Home):_____ (Work):_____ Pager/Cell:_____

Home Address: _____
Street

_____
City State Zip Code

Employer:_____ Position:_____

E-Mail Address: _____

Other members of your immediate family who are patients in our office:_____

Referral Information

Can we thank someone for referring you?
Family member_____

Coworker_____

Friend_____

Doctor_____

Or did you find us on your own?
___Yellow Pages/White Pages

___Newspaper/Magazine

___Location (Sign)

___Direct Mailer

Other_____

Medical

Have you ever had any of the following? Please circle those that apply:

AIDS/HIV
Anemia
Asthma
Chemical Dependencies
Diabetes □ 1 or □ 2
Epilepsy
Heart Disease
Heart Murmur/Art. Valve
Hepatitis
Hepatitis
High Blood Pressure
Joint Replacement
Pacemaker
Radiation Treatment
Rheumatic Fever
Sleep Apnea/CPAP
Tuberculosis
Transplant/Prosthesis

Allergic to Nickel?_____
Recent Surgeries? _____
_____
Are you pregnant? □Yes □No
If so, due date:_____
Nursing? □Yes □No
Drug Allergies?_____
_____

- Do you have any other health problems that need further clarification? □ Yes □ No
  If yes, please explain:_____
  _____
- **Medications** you are taking:_____
  _____
  _____
- Name of Primary Physician and location: _____

- Preferred Pharmacy and location:_____
- Do you currently use **tobacco**? □ Yes □ No If so, how long/type?_____ Do you want to quit?_____

Dental

- **Date of Last Dental Visit: _____**
- Why did you leave your previous dentist?_____
- Are you having tooth pain or problems?_____
  Please Explain_____
- Do you prefer **Nitrous Oxide** (laughing gas) during treatment? □ Yes □ No
- Are you interested in **sedation dentistry**? □ Yes □ No
- Are you interested in **whitening** your teeth? □ Yes □ No
- Are you interested in **veneers**? □ Yes □ No
- If you could change your smile, what would you do?_____
- Do you ever have a bad taste in your mouth? _____
- How often do you awaken with head or jaw pain?_____
- Have you ever had any **complications or allergic reactions** following dental treatment? □ Yes □ No If yes, please explain:_____

To the best of my knowledge, all of the information provided is true and correct. If I ever have any change in my health history, I will inform the doctor at the next appointment.

X_____Date:_____
Signature of patient, parent or guardian

Karen Nation, D.M.D.
13819 English Villa Drive
Louisville, KY 40245
Phone: (502) 244-6886

CONSENT FOR TREATMENT AND OFFICE POLICIES

I willingly consent to the treatment on _____ (name of patient) for all dental procedures deemed necessary for dental diagnosis. I understand that radiographs and certain other procedures are necessary to make a diagnosis. I will be informed of any condition found on examination and any needs that are necessary for comprehensive treatment.

I give consent for all treatments, medications and operations upon the teeth that may be necessary to correct oral deficiency, abnormality and/or infection. I consent to the administration of anesthetic agents for my dental treatment. I understand that as with any dental treatment, there are possible risks involved with my treatment, and that no guarantee is made to the results that may be obtained.

I authorize Dr. Karen Nation to release any information and records concerning my treatment as may be necessary to process insurance claims or payment for the care and treatment provided. I also understand that if for any reason insurance fails to pay for treatment, I am responsible for payment. I also authorize Karen Nation Dentistry to obtain any medical records deemed necessary from my medical doctor or dentist. I agree to have any photos taken of me to be used for education and training.

Dr. Nation takes great pride in scheduling patients for optimum treatment, which means reserving time for each patient individually based on their needs. **I am aware that the cancellation of an appointment without 24-hour notice will result in a $55 fee**.

I have received HIPAA Policy information for Dr. Karen Nation Dentistry. I certify that I have read and fully understand the above consent.

_____ _____

Signature of Patient or Legal Guardian Date