Karen Nation, D.M.D.
Patient Information

Date: _____ Height_____ Weight_____

Patient Name: _____ Preferred Name: _____
Last First MI

□ Male □ Female □ Married □ Single

Birth Date: _____ Social Security #_____

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

Can we send you text messages for appointment reminders? Yes _____ No _____

Home Address: _____
Street

_____
City State Zip Code

Employer: _____ Position: _____

E-Mail Address: _____

Emergency Contact Name: _____ Phone Number: _____

Do you give consent for Dr. Nation and staff to speak with your emergency contact regarding medical/dental? Yes _____ No _____

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

Referral Information

Can we thank someone for referring you?	**Or did you find us on your own?**
Family member _____	___ Direct Mailer
Coworker _____	___ Newspaper/Magazine
Friend _____	___ Location (Sign)
Doctor _____	Other _____

Medical

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

AIDS/HIV	Hepatitis	**Allergic to Nickel?** □ Yes □ No
Anemia	High Blood Pressure	**Recent Surgeries?** _____
Asthma	Joint Replacement	_____
Chemical Dependencies	Pacemaker	**Are you pregnant?** □Yes □No
Diabetes □ 1 or □ 2	Radiation Treatment	If so, due date: _____
Epilepsy	Rheumatic Fever	Nursing? □Yes □No
Heart Disease	Tuberculosis	**Drug Allergies?** □ Yes □ No
Heart Murmur/Art. Valve	Transplant/Prosthesis	_____

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

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 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

MEDICAL RECORDS RELEASE & CONSENT FOR TREATMENT

I authorize Karen Nation Dentistry to obtain any medical or dental records deemed necessary from my medical doctor or dentist.

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 of 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.

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 a cancellation of an appointment without 24-hour notice will result in a $55 fee**.

I certify that I have read and fully understand the above consent.

_____ _____

Signature of Patient or Legal Guardian Date