Welcome!

Dr. Greg Barry 1245 Lawrence St Suite B Port Townsend, WA, 98368 (360) 379-1591

Patient's Legal Name _____ Date of Birth_____/_____/_____

Parent / Guardian Name (if under 18 yrs of age) _____Gender Male__ Female__

Home Phone _____-_____-_____ Mobile _____-_____-_____ SSN (for insurance) ____-____-____

Work (optional) _____-_____-_____ Email_____

Mailing Address _____

_____State_____Zip_____

Emergency Contact _____Relationship _____Phone ____-_____-_____

Dental History

Approximate date of your last dental exam/cleaning _____/_____/_____

Would you like us to contact your previous dental provider for records and x-rays? Yes____ No____

Do you have any specific concerns or pain today? _____

Do you have history of periodontal or "gum" disease? Yes____ No____ Not sure____

Do you grind or clench your teeth? Yes____ No____ If yes, do you wear a night guard? Yes____ No____

Do you snore or have sleep apnea? Yes____ No____ If yes, do you use a CPAP or other appliance? Yes____ No____

Do you wear dentures or partials? Yes____ No____ If yes, are they fitting well? Yes____ No____

Would you like to discuss teeth whitening options? Yes____ No____

Do you experience dry mouth? Yes____ No____ Do you use tobacco? Yes__ No__ Vape? Yes ___ No___

Do you have dental anxiety? Yes____ No____ If yes, is there anything we can do to make your dental visits more comfortable?_____

Medical History

Have you been told to pre-medicate with antibiotics before dental procedures? Yes____ No____

If yes, what do you take? _____

Have you had any of the following surgeries?

Artificial joint Yes____ No____ Date/Procedure_____

Heart surgery Yes____ No____ Date/Procedure _____

Please list the current medications you take:

_____

_____

_____

_____

Please circle any of the following that you have had an allergic reaction to

Penicillin	Ibuprofen	Bee stings
Sulfa	Acetaminophen	Narcotics
Latex	Aspirin	Sedatives
Local anesthetics	Metals	Other_____

Please circle any conditions that you have or have had.

Asthma	Cold sores	Osteoporosis	Dementia
AIDS/HIV	Cancer	Tuberculosis	Alzheimer's
Arthritis	Epilepsy	Glaucoma	Heart Problems
Diabetes	Hepatitis A, B, C	Thyroid conditions	

Are you pregnant? Yes____ Due Date_____

No_____

Today's blood pressure (will be taken by assistant)

Date_____ B.P _____

How did you hear about us, or can we thank someone for referring you?

_____

Financial Policy

Your time in the clinic is reserved just for you. Please give us 24 hours' notice if you must cancel an appointment. You will be charged for missed appointments. All fees are due at the time service is provided. Outstanding account balances over 90 days accrue interest charges at the rate of 1% per month. If you anticipate that your payment may be delayed, please call our office to avoid delinquent status. Your account will be considered for referral to collection if it is not in compliance with your financial agreement. If you have dental insurance, please provide that information to our receptionists.

Release for treatment and surgical care

I hereby give my permission to Dr. Barry and his staff to employ such treatments and therapy as may be deemed professionally necessary or advisable. For most dental procedures, local anesthetic is administered. Risks involved may include heart palpitations, allergic reaction, hematoma, and paresthesia and / or drug cross-reaction. Plaster study models, x-rays, and photos may be released for professional review. X-rays may be released to insurance companies for professional review and may be forwarded to other dentists.

My signature indicates I understand and accept this agreement.

Patient signature_____Date_____

Parent or responsible party_____Date_____