WALDEN
DENTAL
David Frank, DMD

Cancellation & No-Show Appointment Policy

Walden Dental is committed to providing all our patients with exceptional care and with giving everyone the best dental experience possible. When a patient cancels without giving proper notice, it can prevent another patient from being seen and adequately cared for.

No-Show Appointment Definition:

- Rescheduling/cancelling less than 2 hours prior to start time of appointment.
- Arriving 15 minutes or more after start time of appointment
- Not showing up at all to appointment.

Cancelled Appointment Definition:

- Patient notifies office less than 48 hours before a scheduled appointment.

Please call us at 512-337-8560 no later than 1pm two days prior to your scheduled appointment to notify us of any changes. To reschedule a Monday appointment, please give us a call no later than 1pm the previous Thursday. To reschedule a Tuesday appointment, please give us a call no later than 12pm the previous Friday.

A **$75 fee** will be charged for a **no-show** appointment.

A **$50 fee** will be charged for a **cancelled** appointment.

We will require a credit card on file for all patients to reserve time with our office and all information will be securely stored. Patients will only be charged based on the above policy and we will always make several attempts to contact you before processing payment. If you have any questions about our Cancellation Policy, please do not hesitate to reach out to Walden Dental.

PATIENT MEDICAL HISTORY

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PATIENT NAME:_____**DATE:**_____

GENERAL INFORMATION

Date of Birth: _____ **Gender:** ( ) Male ( ) Female

Height: _____ ft. _____ in. **Weight:** _____ lbs

Preferred Phone Number:_____

( ) Cell **( ) Home** **( ) Work**

Preferred Email Address: _____

Occupation: _____

Employer: _____

Work Schedule

( ) Day Shift ( ) Swing Shift

( ) Graveyard Shift ( ) N/A

Marital Status:

( ) Single ( ) Married

( ) Divorced ( ) Widowed

Preferred Pharmacy: _____

Location: _____

Phone Number: _____

How did you hear about us?

( ) Print Advertisement ( ) Drive By

( ) Dental Insurance ( ) Internet Search

( ) Referred by Friend or Family ( ) Referred by Coworker

( ) Social Media (Facebook, Twitter, Instagram, etc.)

( ) Other:_____

When was your last dental appointment?

( ) Within 6 months ( ) More than 3 years

( ) 6 months- 1 year ( ) This is my first dental visit

( ) 1-3 years

Spouse's First and Last Name:

_____

Emergency Contact's Name & Phone Number:

_____

GENERAL DENTAL HEALTH

I think my dental health is… ( ) Excellent ( ) Good ( ) Fair ( ) Poor

If I could change my smile, I would make my teeth… ( ) Straighter ( ) Whiter ( ) Stronger

Other: _____

What are your present dental concerns? _____

Have you had any serious problems with previous dental care? ( ) Yes ( ) No

Please explain:_____

Have you previously worn braces or orthodontic appliances? ( ) Yes ( ) No

Are your teeth sensitive to sweets, hot/cold, or biting pressure? ( ) Yes ( ) No

Check all current dental problems that apply:

( ) Pain ( ) Sores or Ulcers ( ) Broken Teeth ( ) Missing Teeth ( ) Loose Teeth

( ) Grinding/Clenching ( ) TMJ Problems ( ) Bleeding Gums ( ) Bad Taste ( ) Difficulty Chewing

( )Other:_____

DENTAL QUESTIONARRE

Do you consider yourself *a proactive person*? For example, someone who likes to avoid complications and would rather take care of an issue today instead of letting it worsen overtime, which can result in higher costs, more visits, and/or pain down the road**. ( ) Yes ( ) No**

Please Explain:_____

Do you consider yourself *a reactive person*? For example, someone who would rather wait to deal with an issue after it develops, even if that means higher costs, more time, and/or pain to fix down the road. **( ) Yes ( ) No**

Please Explain:_____

Do you have any dental anxiety or fear when visiting the dental office? Would you like to discuss options about how we can keep you as comfortable as possible? **( ) Yes ( ) No**

Please Explain:_____

What do you value most regarding your overall dental health? Please select all that apply and explain below.

- *Cosmetic*- I most value how my teeth look, including wanting my teeth to be straight and/or white.
- *Function* - I most value the ability to enjoy my favorite foods and drinks. I don't want to be limited to just eating on one side, and no foods should be off limits to me.
- *Comfort*- I most value NOT being in pain or having any tooth or gum sensitivities. For example, not being able to eat certain foods due to it causing me pain or discomfort.
- *Longevity*- I most value the ability to have my natural teeth forever. I would like treatment options that will provide the longest outcome, with the least likelihood of needing to have additional treatment on the same tooth in the future.

Please Explain: _____

Do you prefer to break your appointments up into smaller visits and schedule over time, or do you prefer taking care of as much as possible with each appointment?

Please Explain:_____

What is the chief obstacle or objection you may have to visiting a dental office? Please select all that apply and explain below.

- *None*- I come faithfully every 6 months and value my dental health, including taking care of recommended treatment.
- *Time*- I have a very tight schedule and it is difficult finding an appointment time that suits my schedule, being able to take time off from work, or getting in and out for my appointments quickly.
- *No sense of urgency*- Nothing really hurts right now so there has been no need to go to the dentist, or something has been hurting at some level and has been tolerable enough for me to live with it.
- *Budget*- I knew I needed work but didn't have the insurance or income to address any issues found.
- *Lack of Trust*- I was told I needed treatment that I feel I don't need. I felt ripped off and was not provided any data to support why treatment was being recommended.

Please Explain: _____

When the Dentist or Dental Team speaks with you about your treatment options (for example a crown, bridge, deep cleaning, etc.) do you prefer? Please select all that apply:

- A simplified oral explanation and description of the recommended treatment.
- Both detailed oral and visual explanations, which can include videos and pictures demonstrating the recommended treatment.
- Physical models on hand to hold and feel to aid in visualizing the treatment needed.

Are you interested in taking care of any necessary treatment today?

( ) Yes ( ) No

GENERAL MEDICAL HISTORY

I think my overall health is…

( ) Excellent ( ) Good ( ) Fair ( ) Poor

When was your last physical exam?

( ) Within 6 months ( ) 1 – 3 years ago

( ) 6 months – 1 year ago ( ) More than 3 years ago

Are you under the care of a physician?

( ) Yes ( ) No

For what condition(s) are you being treated?

_____

Physician Name, Address, & Phone Number:

_____

_____

Have you had any serious illness, operation, or been hospitalized in the last 5 years?

( ) Yes ( ) No

If yes, what was the problem and when?

_____

_____

Do you have any prosthetic joints?

( ) Yes ( ) No

If yes, please explain:

_____

Have you ever had radiation treatments or therapy to your head and/or neck?

( ) Yes ( ) No

Do you smoke or use tobacco products?

( ) Yes ( ) No

_____

Women's Health Questions:

Are you currently or could you be pregnant? ( ) Yes ( ) No

When are you due? _____

Are you currently nursing? ( ) Yes ( ) No

Do you currently take oral contraceptives, utilize patches, or implants such as IUD for birth control?

( ) Yes ( ) No

DRUG ALLERIGES

Please list all known drug allergies:

_____ _____

_____ _____

_____ _____

CURRENT DRUGS OR MEDICATIONS

Please list all current medications & dosages:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PAST HISTORY OF DRUGS OR MEDICATIONS

Have you ever taken medications for Osteoporosis, chemotherapy, or multiple myeloma (Bisphosphonates), such as Actonol, Boniva, Fosomax, Skelid, and Bonefos. ( ) Yes ( ) No

EXISTING MEDICAL CONDITIONS

Heart: ( ) Yes ( ) No

If yes, please explain:

_____

_____

_____

Blood/ Endocrine: ( ) Yes ( ) No

If yes, please explain:

_____

_____

_____

Liver: ( ) Yes ( ) No

If yes, please explain:

_____

_____

_____

Gastrointestinal: ( ) Yes ( ) No

If yes, please explain:

_____

_____

_____

Lungs: ( ) Yes ( ) No

If yes, please explain:

_____

_____

_____

Kidney: ( ) Yes ( ) No

If yes, please explain:

_____

_____

_____

Other:

Please explain:

_____

_____

PATIENT SIGNATURE:_____ **DATE:**_____

DOCTOR'S SIGNATURE: _____ **DATE:** _____