



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- CHILD



WALDEN
— DENTAL —

David Frank, DMD

PATIENT NAME: _____ DATE: _____

GENERAL INFORMATION

Date of Birth: _____ Gender: () Male () Female Preferred Pharmacy: _____

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

Preferred Phone Number: _____ Pharmacy Phone Number: _____

() Cell () Home () Work

How did you hear about us?

Preferred Email Address: _____
_____ () Print Advertisement () Drive By
() Dental Insurance () Internet Search

Emergency Contact's Name & Phone Number: _____
_____ () Referred by Friend or Family () Referred by Coworker
_____ () Social Media (Facebook, Twitter, Instagram, etc.)
() Other: _____

GENERAL DENTAL HEALTH

When was your last dental appointment?

() Within 6 months () 6 months- 1 year () 1-3 years () More than 3 years () This is my first dental visit

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: _____

GENERAL MEDICAL HISTORY

I think my overall health is...

Excellent Good Fair Poor

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?

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:

DRUG ALLERIGES

Please list all known drug allergies:

CURRENT DRUGS OR MEDICATIONS

Please list all current medications & dosages:

EXISTING MEDICAL CONDITIONS

Heart: Yes No

If yes, please explain:

Liver: Yes No

If yes, please explain:

Lungs: Yes No

If yes, please explain:

Other:

Blood/ Endocrine: Yes No

If yes, please explain:

Gastrointestinal: Yes No

If yes, please explain:

Kidney: Yes No

If yes, please explain:

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

DOCTOR'S SIGNATURE: _____ DATE: _____