Name: ____ **Preferred Name:** _______________
(First and Last) (Optional)
Parent/Guardian (if under 18 years of age): _________________________________
Address: ____
(Street/Mailing Address) (City) (Postal Code)
Email: _______________________________________ **Date of Birth**: __________________

Phone#: ____________________ ____________________ ____________________
(Home) (Cell) (Work)

Emergency Contact
Name: ____ **Relationship**: __________________
Phone#: ____________________ (Ex. Mother, Spouse, etc)

Whom may we thank for referring you to our practice?

- **Yellow Pages**
- **Flyer**
- **Internet/Social Media**
- **Bus Bench**
- **Name of person or other source refering you to our practice:** ____________________

Medical History

Please check off in the box if any of the following to indicate YES in response to the question:

☐ **Are you currently taking any prescriptions or non-prescription medications?**
List of Medications:
____
____

☐ **Have you ever had complications following dental treatment?**
☐ **Are you currently under the care of a physician due to a specific condition?**
☐ **Have you been hospitalized within the last 5 years due to a surgery or illness?**
☐ **Do you use tobacco (includes smoking, chewing tobacco, or vaping)?**
☐ **Do you have any other conditions, diseases, etc., not listed above that we should be aware of?**

If any of the previous questions are checked off, please explain:

WOMEN ONLY: Are you currently pregnant? ○ **Yes** ○ **No** **Due Date:** ______________________

Family Physician or Specialist: ________________________________ **Phone#:** _____________

Please indicate if you have experienced any of the following:

- ☐ Pre-medication
- ☐ Allergy
- ☐ Diabetes
- ☐ Hearing Disabled
- ☐ Kidney Disease
- ☐ Pacemaker
- ☐ Respiratory Issues
- ☐ Artificial Joints
- ☐ Cancer
- ☐ Dizziness/Fainting
- ☐ Excessive Bleeding
- ☐ HBP
- ☐ Heart Disease
- ☐ TMJ
- ☐ Hard to freeze
- ☐ Liver Disease
- ☐ Anxiety
- ☐ Autoimmune

☐ Please list all allergies or any other health issues:

____

____

Cancellation Policy

We at YQR Dental Studio, understand that a situation may arise in which you must cancel or change your appointment. In such situations, we respectfully ask that you provide at least 24 hours notice to change and/or cancel appointments. Your appointment(s) are important to our team. With advance notice, it will allow our team to adjust their schedules accordingly. Failure to cancel your appointment or by not showing up for your appointment reserves YQR Dental Studio the right to charge you a fee for the time lost.

Authorization & Release

By signing this form, I certify that I have provided accurate information to YQR Dental Studio to the best of my knowledge on behalf of myself or my dependent. If there are any changes to my health or my dependent, I will advise the dental office immediately.

By signing this form, I authorize YQR Dental Studio; therefore, the doctor, Dr. Grant Roland & its team, to perform the necessary dental services I or my dependent may need during diagnosis and treatment with my informed consent.

By signing this form, I authorize the release of written records to any referring or treating dentist, physician, medical facility and insurance company for legal documentation.

Patient/Guardian Signature: ____________________________ **Date:** __________________

Reviewed by: _____________________________ **Date:** __________________

(To be completed by YQR Dental Studio)