

PATIENT INFORMATION UPDATE

Dr./Mr./Mrs./Ms./Miss/Other _____ Last Name _____ First Name _____ Middle Name _____
Today's Date: _____
Residence Address: _____ City _____ State _____ Zip _____
Residence Phone #: _____ - _____ - _____ Cellular phone/pager #: _____ - _____ - _____
E-mail address: _____
Birthdate: _____ Social Security #: _____ - _____ - _____ TX Drivers License #: _____
Employer: _____ Business Phone #: _____ - _____ - _____
Business Address: _____ City _____ State _____ Zip _____
If child, name of parents: _____ If student, name of school: _____
Spouse's Name: _____ Spouse's Employer: _____ Phone #: _____ - _____ - _____
Spouse's Business Address: _____ City _____ State _____ Zip _____

First person to contact in case of emergency: _____ Phone #: _____ - _____ - _____
Address: _____ City _____ State _____ Zip _____
Nearest relative/friend not living with you: _____ Phone #: _____ - _____ - _____
Address: _____ City _____ State _____ Zip _____

ACCOUNT INFORMATION

Person responsible for payment: _____ Phone #: _____ - _____ - _____
Are any of your family members patients? YES NO Please list: _____
If yes, do you want to be listed under the SAME or DIFFERENT accounts
Will you need financial arrangements to help with the cost of your dental treatment? YES NO

COSMETIC DENTISTRY

Please check any of the following cosmetic alternatives you might be interested in:
 Teeth straightening Teeth whitening Filling spaces
 Replacing silver fillings with tooth colored fillings Bonding Improving the overall appearance of your smile
 Porcelain veneers

DENTAL HEALTH UPDATE (Confidential)

Please check if you have experienced any of the following:

<input type="checkbox"/> Periodontal/gum disease (How long ago? __)	<input type="checkbox"/> Loose teeth	<input type="checkbox"/> Jaw clicking or popping
<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Food packing between teeth	<input type="checkbox"/> Stiff neck muscles
<input type="checkbox"/> Receding gums	<input type="checkbox"/> High or rough fillings	<input type="checkbox"/> Pain/soreness around eyes, ears, jaw area
<input type="checkbox"/> Swelling of the gum	<input type="checkbox"/> Bad breath or taste in mouth	<input type="checkbox"/> Tension headaches
<input type="checkbox"/> Pain or soreness in gums	<input type="checkbox"/> Sensitivity to : __hot __cold	<input type="checkbox"/> Difficulty in opening/closing mouth
<input type="checkbox"/> Growths or swellings in mouth (How long existed? __)	<input type="checkbox"/> __pressure __biting	<input type="checkbox"/> Difficulty in chewing/swallowing
<input type="checkbox"/> Spaces between teeth	<input type="checkbox"/> __chewing __tooth brushing	
<input type="checkbox"/> Drifting teeth	<input type="checkbox"/> __sweets	
	<input type="checkbox"/> Clenching/grinding teeth	

MEDICAL HEALTH HISTORY (Confidential)

Name: _____

Name of Primary Physician: _____ Specialty: _____
Address: _____ City _____ State _____ Zip _____ Phone #: _____ - _____ - _____

Please check if you have or have ever had any of the following:

CARDIOVASCULAR/BLOOD

- Heart Murmur
- Artificial Heart Valve
- Mitral Valve Prolapse
- Heart Attack/Disease
- Heart Failure
- Heart Surgery
- Heart Pacemaker
- Chest Pains/Discomfort
- Circulatory Problems
- Rheumatic Fever
- Swollen Ankles
- High Blood Pressure
- Low Blood Pressure
- Excessive Bleeding
- Bruise Easily
- Anemia
- Hemophilia
- Leukemia
- Sickle Cell Disease
- Blood Transfusion

NERVOUS SYSTEM

- Stroke
- Epilepsy/Convulsions
- Fainting/Dizziness
- Headaches

- Numbness/Tingling
- Nervous Disorders
- Psychiatric Treatment

RESPIRATORY

- Tuberculosis
- Emphysema
- Asthma
- Hay Fever/Allergies/Hives
- Persistent Cough
- Shortness of Breath
- Respiratory Disease

ENDOCRINE/URINARY

- Diabetes
- Thyroid Disease
- Kidney/Bladder Trouble

DIGESTIVE

- Hepatitis A (Infection)
- Hepatitis B (Serum)
- Jaundice
- Ulcers
- Liver Disease
- Typhoid Fever

BONES/MUSCLES

- Fractured Bones
- Artificial Joints
- Back Problems

EYES/EARS/NOSE/THROAT/SKIN

- Glaucoma
- Ringing in Ears
- Sinus Problems
- Frequent Nosebleeds
- Scarlet Fever
- Herpes/Fever Blisters
- Lupus
- Measles/Mumps/Chicken Pox

OTHER

- AIDS/HIV Positive
- Cancer
- Chemotherapy/Radiation
- Venereal Disease
- Anorexia/Bulimia
- Recent Weight Loss
- Alcoholism
- Drug Addiction
- Surgical Implants
- Other: _____

If you have marked any of the above, please briefly describe: _____

Please list any past hospitalizations/surgeries (minor or major): _____

Please describe any current medical treatment, impending operations, or other information that may affect your dental treatment: _____

MEDICATIONS

List medications you are currently taking: _____

Pharmacy Name: _____ Phone #: _____

ALLERGIES TO MEDICATIONS

- Penicillin
- Codeine
- Aspirin
- Sulfa
- Barbiturates
- Local Anesthesia
- Other: _____

Have you ever been premedicated for your dental appointments in the past? YES NO

Do you frequently drink alcohol? YES NO Do you smoke tobacco? YES NO Do you use smokeless tobacco? YES NO

The above information is accurate and complete to the best of my knowledge. If any change occurs in my dental and/or medical health, I will report it to this office as soon as possible. I understand that I am and/or my parent or guardian is financially responsible for all fees related to my dental treatment.

Patient Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____