

WELCOME TO OUR OFFICE! Please complete the following so that we may provide you with the safest and most comfortable, comprehensive, and efficient dental care possible.

PATIENT INFORMATION

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: _____
Referred by: _____
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: _____

Will you need financial arrangements to help with the cost of your dental treatment? YES NO

DENTAL INSURANCE

Please fill out the following and present an insurance card(s) and/or a completed insurance form(s) to the receptionist.

Primary Dental Insurance Company: _____ Group #: _____
Address: _____ City _____ State _____ Zip _____ Phone #: _____ - _____ - _____
Policy Holder's Name: _____ Relationship of Patient to Policy Holder: _____
Policy Holder's Birthdate: _____ Policy Holder's Social Security #: _____ - _____ - _____
Policy Holder's Employer: _____

Secondary Dental Insurance Company: _____ Group #: _____
Address: _____ City _____ State _____ Zip _____ Phone #: _____ - _____ - _____
Policy Holder's Name: _____ Relationship of Patient to Policy Holder: _____
Policy Holder's Birthdate: _____ Policy Holder's Social Security #: _____ - _____ - _____
Policy Holder's Employer: _____

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am financially responsible for all charges, regardless of insurance coverage.

Responsible Party Signature: _____ Date: _____

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

For Women: Are you pregnant? YES NO Due Date: _____ Nursing? YES NO Taking Birth Control Pills? YES NO

DENTAL HEALTH HISTORY (Confidential)

Name: _____

Previous Dentist: _____ Specialty: _____

Address: _____ City _____ State _____ Zip _____ Phone #: _____ - _____ - _____

Date of last cleaning and exam: _____ Date of last full mouth x-rays: _____

Reason for changing dentists: _____

Have you ever had an unfavorable experience at a dental office? YES NO Briefly describe: _____

Are you nervous about receiving dental treatment today? YES NO

IMMEDIATE DENTAL CONCERN: _____

Please check if you have experienced any of the following:

____ Periodontal/gum disease

(How long ago? ____)

____ Bleeding gums

____ Receding gums

____ Swelling of the gums

____ Pain or soreness in gums

____ Growths or swellings in mouth

(How long existed? ____)

____ Spaces between teeth

____ Drifting teeth

____ Loose teeth

____ Food packing between teeth

____ Infection around teeth

____ High or rough fillings

____ Bad breath or taste in mouth

____ Sensitivity to: __ hot __ cold

__ pressure __ biting

__ chewing __ tooth brushing

__ sweets

____ Clenching/grinding teeth

____ Jaw clicking or popping

____ Stiff neck muscles

____ Pain/soreness around eyes, ears,

jaw area

____ Tension headaches

____ Difficulty in opening/closing

mouth

____ Difficulty in chewing/swallowing

How often do you brush your teeth? _____

floss your teeth? _____

Do you use a supplemental fluoride rinse/gel at home? _____ What kind? _____

List any additional dental aids you use at home (i.e. electric toothbrush) _____

Have you ever lost any teeth? YES NO From what cause? _____

Have you ever injured your mouth/teeth in an accident? YES NO Briefly describe: _____

Have you had any orthodontic work? YES NO How long ago? _____

Have you had oral surgery? YES NO How long ago? _____ Describe: _____

Have you had any periodontal treatment? YES NO How long ago? _____ Describe: _____

Do any of your family members wear dentures/partials? YES NO

IF YOU WEAR A PARTIAL OR DENTURE, PLEASE COMPLETE THE FOLLOWING:

What type of partial/denture do you have? UPPER LOWER BOTH

How long have you worn a partial/denture? _____

Are you satisfied with the appearance? _____ comfort? _____ chewing ability? _____ your speech? _____

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

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: _____