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940-382-9755

PATIENT INFORMATION

Patient: ______________________ Birthdate: __________ Age: __________

Address: ______________________ City: __________ State / Zip: __________

Home #: ______________ Wk#: ______________ Cell #: ______________

Patient's Employer: ______________________

E-mail Address : ______________________

Person to contact for emergency? ______________________ Phone # ______________

Which pharmacy do you use for prescriptions ______________ Phone # ______________

Whom may we thank for referring you to our office? ______________________

Are you available for short notice appt's? __________ When? ______________

SPOUSE or RESPONSIBLE PARTY INFORMATION

Name: ______________________ Birthdate: __________ S.S.N.: ______________

Address: ______________ City: __________ State: __________ Zip: __________

Employer: ______________________ Work # ______________

I understand that I am responsible for payment for Dental services provided in this office for myself or dependents. Payment is due at the time of services rendered I further understand that 1.5% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to collect this debt.

Signature of person responsible for account. ______________________

INSURANCE INFORMATION

Primary

Name of Insured: ______________________ Employer: ______________________

Insurance Company Name and #: ______________________

Address: ______________ City: __________ State: __________ Zip: __________

Birthdate: ______________ ID #/SS #: ______________ Group #: ______________

Patient's Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

I have read this form and agree to be financially responsible. ______________

I authorize payment of benefits directly to the provider. ______________

I authorize the release of all information to the insurance Co. ______________

MEDICAL HEALTH INFORMATION

Name of your Doctor? ______________________ Phone: ____________

Address: ____________ City: ________ State: ________ Zip: ________

Has there been any change in your health in the last year? ☐ yes ☐ no ☐ not sure
If yes please explain. ______________________

Have you ever been hospitalized? ☐ yes ☐ no ☐ not sure
If yes please explain. ______________________

Are you currently receiving treatment or regular medical care? ☐ yes ☐ no ☐ not sure
If yes please explain. ______________________

Are you allergic to or had any unusual reactions to medications? ☐ yes ☐ no ☐ not sure
If yes please explain. ______________________

Are you or have you had an addiction to alcohol or drugs? ☐ yes ☐ no ☐ not sure
If yes please explain. ______________________

Have you used any drugs or alcohol in the last 24 hours? ☐ yes ☐ no ☐ not sure
If yes please explain. ______________________

Are you presently taking or have you ever taken any of the following medications?

☐Blood thinners ☐Blood pressure ☐Steroids ☐Antihistamines
☐Nitroglycerin ☐Birth control pills ☐aspirin ☐Medication for heart problems
☐ For diabetes ☐Over the counter pain medications ☐Synthroid / Thyroid medication

List any Medication you are presently taking:

Medication	Dosage	Date started	Reason you are taking medication

Have you ever had or been treated by a doctor for (circle any conditions that apply):

AIDS/HIV Anemia Asthma Dialysis Chemo Emphysema Rheumatism
Psoriasis Diabetes Hay fever Jaundice Ulcers Tuberculosis Heart Murmur
Arthritis Tumors Seborrhea Hepatitis Sinus Rheumatic Fever High blood pressure
numbness Anxieties Cancer Seizures Stroke Liver Disease mitral valve prolapse
Migraines Hemophilia Heart Attack Damaged Heart Valves

Do you use tobacco products? Smoke? How many ________ Dip? how often? ________

WOMEN: Are you pregnant or could you be pregnant? ☐ yes ☐ no ☐ not sure

Have you ever had any type of joint replacements? Knee/hip ☐ yes ☐ no ☐not sure
If yes please explain. ______________________

Have you ever taken any of the following diet medications? Redux Pondimin Phen/Phen

Are there any other problems about your health that you know of? ☐ yes ☐ no ☐ not sure
If yes please explain. ______________________

DENTAL HISTORY

When was your last dental visit and x-rays? ______________________

Who was your previous D.D.S.? ______________ May we request your records? ________

What is the reason for your dental visit today? ______________________

What is your major dental concern? ______________________

Have you ever fainted during a dental visit? ☐ yes ☐ no ☐ not sure
If yes please explain. ______________________

Have you experienced any reaction to any medication or anesthetic? ☐ yes ☐ no ☐ not sure
If yes please explain. ______________________

Have you had nitrous oxide sedation? ☐ yes ☐ no ☐ not sure
Was it a good experience? ______________ ☐ yes ☐ no ☐ not sure

Have you had any other complications following dental treatment? ☐ yes ☐ no ☐ not sure
If yes please explain. ______________________

Have you had any injury to your teeth, jaws, or face? ☐ yes ☐ no ☐ not sure
If yes please explain. ______________________

Would you change anything about the appearance of your teeth? ☐ yes ☐ no ☐ not sure
If yes please explain. ______________________

Do your gums bleed when you brush your teeth? ☐ yes ☐ no ☐ not sure

Have you ever been told you have gum disease? ☐ yes ☐ no ☐ not sure

Have you ever seen a periodontist? ☐ yes ☐ no ☐ not sure
If yes please explain. ______________________

Are any of your teeth sensitive to hot, cold, or pressure? ☐ yes ☐ no ☐ not sure

Do you experience pain or clicking in your jaw joints? ☐ yes ☐ no ☐ not sure

Do you wear or have a night guard? ☐ yes ☐ no ☐ not sure

Do you have or have you ever had partials/dentures or implants? ☐ yes ☐ no ☐ not sure

Have you ever had orthodontic care? ☐ yes ☐ no ☐ not sure
If yes when. ______________________

Have you ever had an allergic reaction to latex? ☐ yes ☐ no ☐ not sure

SIGNATURE OF PATIENT: I understand the need for truthful answers. To the best of my knowledge, the answers I have given are accurate. I also understand the importance to report any change in my medical/dental status to the dentist at the earliest possible time. I give my permission to the dentist to obtain any additional information from my physician.

SIGNATURE: ______________________ DATE: ______________

If other than patient, indicate relationship: ______________ ***STOP***