

PATIENT INFORMATION

(THIS INFORMATION IS NECESSARY FOR OUR FILES AND WILL BE CONSIDERED CONFIDENTIAL)

TODAY'S DATE _____

| | | |
|--------------------------------------|--|-------------------------------|
| PATIENT'S LAST NAME () | FIRST NAME | MIDDLE |
| HOME PHONE | CELL PHONE () | |
| CURRENT STREET ADDRESS | CITY | STATE ZIP |
| PLACE OF EMPLOYMENT | EMPLOYER'S ADDRESS | CITY ZIP |
| OCCUPATION | | () |
| PATIENT'S BIRTHDATE | SOCIAL SECURITY NUMBER | TEXAS DRIVER'S LICENSE NUMBER |
| | | WORK PHONE EXT. |
| IF A STUDENT, NAME OF SCHOOL/COLLEGE | WHOM MAY WE THANK FOR REFERRING YOU TO US? | |

FINANCIAL INFORMATION

| | |
|---|-------------------------------------|
| NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT | RELATIONSHIP |
| CURRENT STREET ADDRESS | CITY STATE ZIP |
| HOME PHONE () | CELL PHONE () WORK PHONE () |
| PLACE OF EMPLOYMENT | EMPLOYERS ADDRESS CITY ZIP |
| IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? | YES NO SOCIAL SECURITY NUMBER |

DENTAL INSURANCE INFORMATION

| | | |
|----------------------------|--------------------------|---------------------|
| INSURED PERSON'S FULL NAME | | () |
| SOCIAL SECURITY NUMBER | RELATIONSHIP TO PATIENT | WORK PHONE |
| INSURANCE COMPANY NAME | GROUP ID NUMBER | UNION OR LOCAL NAME |
| EMPLOYER NAME | FULL ADDRESS OF EMPLOYER | |

DO YOU HAVE OTHER DENTAL COVERAGE? YES NO (IF YES, COMPLETE THE FOLLOWING)

| | | |
|----------------------------|--------------------------|---------------------|
| INSURED PERSON'S FULL NAME | | () |
| SOCIAL SECURITY NUMBER | RELATIONSHIP TO PATIENT | WORK PHONE |
| INSURANCE COMPANY NAME | GROUP ID NUMBER | UNION OR LOCAL NAME |
| EMPLOYER NAME | FULL ADDRESS OF EMPLOYER | |

FOR YOUR INFORMATION

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he/she deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his/her staff.

SIGNATURE OF RESPONSIBLE PARTY _____ RELATIONSHIP _____ DATE _____

PLEASE COMPLETE REVERSE SIDE

HEALTH QUESTIONNAIRE

NAME OF PHYSICIAN _____

CITY _____

DATE OF LAST PHYSICAL _____

PLEASE "X" EACH BOX IF THE ANSWER IS "YES", LEAVE BLANK IF "NO"
HAVE YOU HAD . . .

- HEART PROBLEMS
- HIGH BLOOD PRESSURE
- LOW BLOOD PRESSURE
- CIRCULATORY PROBLEMS
- RHEUMATIC FEVER
- HEPATITIS
- DIABETES
- RADIATION TREATMENTS

- EPILEPSY
- KIDNEY PROBLEMS
- NERVOUS PROBLEMS
- TUBERCULOSIS
- EXCESSIVE BLEEDING
- CEREBAL PALSY
- SCARLET FEVER
- MALIGNANCIES

- CHRONIC SINUS
- CHRONIC EAR PROBLEMS
- ANEMIA
- ARTHRITIS
- ADENOIDS REMOVED
- TONSILS REMOVED
- ASTHMA
- VENEREAL DISEASE/HERPES

OTHER HEALTH COMPLICATIONS: _____

HAVE YOU EVER TESTED POSITIVE FOR HTLV III (AIDS)? YES _____ NO _____

DO YOU USE TOBACCO PRODUCTS? YES _____ NO _____

ARE YOU ALLERGIC TO:

- PENICILLIN ASPIRIN CODEINE LOCAL ANESTHETICS (i.e. Novacaine)

OTHER: _____

ARE YOU PREGNANT? _____ IF YES, HOW MANY MONTHS? _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: _____

PLEASE LIST ANY OTHER MEDICAL CONDITIONS YOU FEEL THE DOCTOR SHOULD BE AWARE OF _____

DENTAL HEALTH INFORMATION

NAME OF PREVIOUS DENTIST _____

CITY _____

DATE OF LAST VISIT _____

ARE YOU SENSITIVE TO:

- HEAT COLD SWEETS CHEWING

HAVE YOU HAD ANY INJURIES TO THE MOUTH / JAW AREA? _____

IF YES, PLEASE EXPLAIN: _____

CHECK UP APPOINTMENTS

WHEN WAS YOUR LAST CHECK-UP AND CLEANING?: _____

FOR ALL PATIENTS

PLEASE LIST ANY PREVIOUS EXPERIENCES OR PROBLEMS YOU WOULD LIKE THE DOCTOR TO BE AWARE OF: _____

SIGNATURE OF RESPONSIBLE PARTY _____

RELATIONSHIP _____

DATE _____

S.I. (1) _____

S.I. (2) _____