



2111 E University Dr Ste 20  
Prosper, TX 75078  
972-346-9998

**GETTING TO KNOW YOU AS OUR PATIENT**

DATE: \_\_\_\_\_

PATIENT NAME	Home Address	City, State, Zip
Home ( ) Cell ( ) Work ( )	SS#  Drivers License #	Birthdate / /
Martial Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Male <input type="checkbox"/> Female	E-Mail

**INSURANCE**

Primary Insurance Company _____	Subscriber _____
Group # _____	ID# _____

**Responsible Party and/or Insurance Subscriber Information (if different from above)**

Name	Home Address	City, State, Zip
Home ( ) Cell ( ) Work ( )	SS#  Drivers License #	Birthdate / /
Martial Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Patient
Employer:	Business Address:	Occupation:

**How did you hear about our Office?**

**Who selected this Office? Please circle Self Spouse Parent Employer**

**Referred by:** A Friend --- Yellow Pages --- Relative --- Insurance Plan --- Website --- FOL --- Newspaper Ad --- 380 Guide --- Office Sign - MOM E' Guide --- Other \_\_\_\_\_

If you were referred, whom may we thank for referring you? \_\_\_\_\_

**CONSENT**

\* I will answer all health questions to the best of my knowledge

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures the judgement of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

**TERMS AND CONDITIONS**

The office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements must be paid for at the time the services are performed. **I understand that the dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare by insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.**

Assignment of insurance: I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this Office benefits accruing to my under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you or you assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

**There may be a charge for any missed appointments or appointments not cancelled 48 hours before the appointment time.**

**X** \_\_\_\_\_

**Patient Signature/Parent/Guardian (I have read and agree to the Content and terms and conditions listed above)**

## PATIENTS DENTAL HEALTH

Why have you come in to see us today? (e.g.: pain, checkup, etc.) \_\_\_\_\_

Previous Dentist \_\_\_\_\_ Last Visit \_\_\_\_\_ Date of last cleaning \_\_\_\_\_

Reasons for changing dentists: \_\_\_\_\_

Have you had an unfavorable dental experience? \_\_\_\_\_

Are you nervous about seeing a dentist?  Yes!  No if yes, please tell us why: \_\_\_\_\_

How often do you brush? \_\_\_\_\_ Do you floss?  Yes  No How Often? \_\_\_\_\_

Please circle each:

Y N I clench or grind my teeth during the day or while sleeping	Y N My gums feel tender or swollen	Y N I want my teeth straighter
Y N My gums bleed while brushing or flossing	Y N I have problems eating	Y N I want my teeth whiter
Y N I like my smile	Y N I have had orthodontics	Y N I have had a facial or jaw injury
Y N I avoid brushing part of my mouth due to pain		

What are your dental priorities? \_\_\_\_\_  
(e.g.: Dental Health, Financial considerations etc.)

## PATIENTS MEDICAL HISTORY

I consider my health to be (please check one)  Excellent  Good  Fair  Poor

Do you have or have you had any of the following? Please circle Y for yes and N for no

1. Y N Heart Disease	22. Y N Liver Disease	36. Y N AIDS
2. Y N Heart Murmur/Mitral Prolapse	23. Y N Jaundice	37. Y N Immune Suppressed Disorder
3. Y N Stroke	24. Y N Hepatitis Type _____	38. Y N Hearing Loss
4. Y N Congenital Heart Lesions	25. Y N Diabetes	39. Y N Fainting Spells
5. Y N Rheumatic Fever	26. Y N Excessive Urination and/or Thirst	40. Y N Glaucoma
6. Y N Abnormal Blood Pressure	27. Y N Infectious Mononucleosis (Mono)	41. Y N History of Emotional or Nervous Disorders
7. Y N Anemia	28. Y N Herpes	
8. Y N Prolonged Bleeding Disorder	29. Y N Arthritis	
9. Y N Tuberculosis or Lung Disease	30. Y N Sexually Transmitted/Venereal Disease	42. Y N Thyroid Disease
10. Y N Asthma	31. Y N Kidney Disease	
11. Y N Hay Fever	32. Y N Tumor or Malignancy	
12. Y N Sinus Trouble	33. Y N Cancer/Chemotherapy	
13. Y N Epilepsy/Seizures	34. Y N Radiation Treatment	
14. Y N Ulcers	35. Y N History of Drug Addiction	
15. Y N Implants/Artificial Joints: <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Other: _____		
16. Y N I smoke or use Tobacco. If yes, how much per days? _____ How many years? _____		
17. Y N I have consumed alcohol with in the last 24 hours.		
18. Y N I usually take an antibiotic prior to dental treatment		
19. Y N Have you ever taken Fen-Phen or Redux?		
20. Y N I have had major surgery: Year _____ Type of operation _____ Year _____ Type of operation: _____		
21. Y N Do you have any other medical problem or medical history NOT listed on this on this form: _____		

### Office Use Only: Doctor's Notes

<p>Are you allergic to any of the following? Please circle Y for yes and N for no</p> <p>44. Y N Aspirin</p> <p>45. Y N Ibuprofen</p> <p>46. Y N Sulfa Drugs/Sulfites/Sulfides</p> <p>47. Y N Penicillin</p> <p>48. Y N Codeine</p> <p>49. Y N Latex, Metals, Plastics</p> <p>50. Y N Local Anesthetics (Novocaine)</p> <p>51. Y N Other Medications _____</p>	<p>Please list all medication your are currently taking: (if you have a list we are happy to make a copy)</p> <p>Medicine _____ Condition _____</p> <p>Medicine _____ Condition _____</p> <p>Medicine _____ Condition _____</p> <p>Physicians Name _____ Phone _____</p> <p>Address _____</p>
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### In case of an emergency please contact

Name: _____	Relationship _____	Phone _____
Name: _____	Relationship _____	Phone _____
** I authorize the above information is true and correct to the best of my knowledge.		
X _____	/ /	XX _____
Signature Patient/Parent/Guardian	Date	Dr /Staff Signature
		Date

