4450 East Highway 287 Midlothian, Texas 76065 972-723-2300



211 West Belt Line Road Cedar Hill, Texas 75104 972-291-4281

To help us meet all your dental needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Name	Pe	Perferred Name		Date		
Soc.Sec#	Birthdate	BirthdateEmail				
Address						
Home Phone	Cell			Work		
Check Appropriate Box: □Chi	ild □Single □Married	d □Separated	□Divorced I	⊐Widowed		
Gender: Male/Female						
If Student, Name of School						
Patient's/Parent's Employer		Work Phone:				
Business Address		City_		St	Zip	
Spouse or Parent's Name		Emp	loyer	Work Pl	none	
Whom May We Thank for Refe	rring You?					
Person to Contact in Case of Eme	ergency?			_ Phone #		
What is the reason for your dent	al visit today?					
Responsible Part	v					
•						
Name of Person Responsible for the	his Account					
Address						
Soc.Sec#						
Driver's License #	• •			Work Phone		
Is this Person Currently a Patient		□Yes	□No			
For your convenience, we offer t						
Payment is due in full at each ap	ppointment: □Cash	□Check	□Credit Card	□Care Cr	redit	
	Insuranc	e Inform	nation			
Insured's Name			Insured	's SS#		
Insurance Company			ID#		Group#	
Insurance Co. Address						
Insurance Co. Phone No	lnsured	d's Employer				
As of April 14, 2003, federal law offered a copy from this office o			of our Notice	of Privacy Pra	ctices. I have been	
Date	Signature					

Patient Medical History Office Phone Date of Last Exam Physician Yes No Any changes in general health in the past year Yes No 8. Are you allergic to or have you had any reaction 1. Are you under medical treatment now? to the following? 2. Have you been hospitalized for any surgical Local Anesthetics (e.g. Novacain) operation or serious illness within the last 5 years? Penicillin or any other Antibiotics If Yes, Please Explain Sulfa Drugs Barbiturates Sedatives 3. Are you taking any medications(s) including nonlodine prescription medicine? Aspirin If Yes, what medication(s) are you taking? Any Metals (e.g. nickel, mercury, etc) Latex Rubber Other 9. Do you have a persistent cough or throat 4. Do you require antibiotics before dental treatment? clearing not associated with a knowm 5. Do you use tobacco? illness (lasting more than 3 weeks)? 6. Do you use controlled substances? 10. Women Only: Are you pregnant or think you may be? 7. Do you have or have you had any of the Are you nursing? following? Are you taking oral contraceptives? Yes No Yes No Yes No High Blood Pressure Heart Disease Chest Pains Heart Attack Cardiac Pacemaker Easily Winded Rheumatic Fever Heart Murmur Stroke Hay Fever/Allergies Swollen Ankles Angina Frequently Tired Tuberculosis Fainting/Seizures Anemia Radiation Therapy Asthma Low Blood Pressure Emphysema Glaucoma Epilepsy/Convulsions Cancer Recent Weight Loss Arthritis Liver Disease Leukemia Diabetes Joint Replacement or Implant Heart Trouble Kidney Diseases Hepatitis/Jaundice Respiratory Problems Sexually Transmitted Disease Mitral Valve Prolapse AIDS or HIV Infection Stomach Troubles/Ulcers Thyroid Problem Other **Patient Dental History** Name of Previous Dentist & Location Date of Last Exam Yes No Yes No 1. Do you like your smile? 8. Do you have frequent headaches? 2. Are your teeth sensitive to hot or cold liquids/foods? 9. Do you clench or grind your teeth? 3. Are your teeth sensitive to sweet or sour liquids/foods? 10. Do you bite your lips or cheeks frequently? 4. Do you feel pain to any of your teeth? 11. Have you had any orthodontic treatment? 5. Do you have any sores or lumps in or near your mouth? 12. Have you ever had any past difficult extractions? 6. Have you had any head, neck, or jaw injuries? 13. Have you ever had any prolonged bleeding 7. Have you ever experienced any of the following following extractions? problems in your jaw? 14. Do you wear partials or dentures or implants Clicking If yes, date of placement_ Pain (joint, ear, side of face) 15. Do your gums bleed while brushing or flossing? Difficulty in opening or closing 16. Have you ever received oral hygiene instructions Difficulty in chewing regarding the care of your teeth and gums?

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release my information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I will be responsible for payment of all services rendered on my behalf or my dependents. I agree to pay the \$25 missed appointment/no show fee should I fail to provide notice of cancellation 24-hours in advance of scheduled appointments.

X	
Signature of patient (or parent/guardian if minor)	