**The Dental Health Center** **PATIENT INFORMATION FORM**

**3248 S. Alameda, Corpus Christi, TX 78404**

**361-888-8603 office, 361-888-8610 fax**

Name:_____ Date of Birth:_____ Sex: _____ Age:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email:_____ Driver's license #_____

Address:_____ City:_____ State:_____ Zip:_____

Spouse Name & #:_____ Emergency Contact & #:_____

Employer/Occupation:_____ SS #_____

Primary Dental Insurance:_____ Group #:_____

Ins Subscriber's name/DOB:_____ ID Number:_____

Relationship to Patient: _____ * Note: Our office does not file with Secondary Insurance.

Responsible Party (If other than patient or Ins subscriber): _____ Phone: _____

Name of Medical Doctor:_____ Date of last visit to Dr:_____

Name of Previous Dentist:_____ Date of last visit to Dentist:_____

Referred to us by:_____

Payment Agreement and Acknowledgement:

I agree that I am responsible for all services rendered to the Patient and that payment is due and payable to the Practice at the time services are rendered and that health, dental, and accident insurance policies are an arrangement between my insurance carrier and me. I understand that while the Practice will file claims with my insurance company on my behalf, I remain responsible to the Practice for what is not paid by my insurance claim. I also understand that if the Practice cannot verify insurance benefits eligibility for me prior to treatment that I will pay in full for the services at the time they are rendered. I understand that the Practice may charge: **1) a late fee if payment on my account is not received by the due date; 2) an amount equal to $35.00 for each returned check; and 3) a fee for each appointment that is missed/cancelled without at least 24 hours advance notice.**

I agree to the extent permitted by law, that if my account balance is referred to any agency or attorney for collection purposes, to pay reasonable attorney's fees and any expenses or costs relating to the collection proceeding, including court costs. I understand that if treatment or care is suspended at any time by the patient, all fees for professional services rendered will be immediately due and payable. I authorize payment directly to the Practice.

**Signature of Patient:_____ Date:_____**

**Signature of Responsible Party: _____ Date:_____**

**(If different that patient)**

## DENTAL HEALTH HISTORY

Are you apprehensive about dental treatment?..... Y N

Have you had bad experience with dental treatment?.. Y N

Do you chew only one side of your mouth?..... Y N

Do your gums bleed easily?..... Y N

Do your gums feel swollen or tender?..... Y N

Have you ever noticed sores in/around your mouth?.... Y N

Are your teeth sensitive?..... Y N

Do your teeth hurt with hot?..... Y N

Do your teeth hurt with cold?..... Y N

Do your teeth hurt with sweet?..... Y N

Do you take fluoride supplements?..... Y N

Have you had complications with extractions?..... Y N

Are you happy with appearance of your teeth?... Y N

Do you clench or grind your jaws?..... Y N

Does your jaw make noise or bothers you?..... Y N

Does your jaw get stuck so it can't open?..... Y N

Do you have pain around your ears?..... Y N

Do you have jaw soreness or headaches when you wake in the mornings?..... Y N

Are you a gum chewer or pipe smoker?..... Y N

Do you snore?..... Y N

Do you have problems with bad breath?..... Y N

Have you ever had orthodontic treatment?..... Y N

Do you want your teeth whiter?..... Y N

## MEDICAL HEALTH HISTORY

List any medications you are taking, including non-prescription meds:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

During the past 12 months, have you taken any of the following?

Antibiotics…….. Y N

Blood thinners…… Y N

Tranquilizers/Sedatives…… Y N

Nitroglycerin…… Y N

Steroids/Cortisone…… Y N

Aspirin…… Y N

High blood pressure meds…… Y N

Insulin, Orinase…… Y N

Digitalis or heart medicine…… Y N

Natural remedies…… Y N

Allergies/Reactions/Hospitalizations:

_____

_____

_____

Do you have, or have you had, any of the following?

| | Yes | No |
|---|---|---|
| Allergy Problems | Y | N |
| Sinus Problems | Y | N |
| Asthma | Y | N |
| Taking Allergy Medication | Y | N |
| Blood Problems | Y | N |
| Easy bruising | Y | N |
| Abnormal bleeding | Y | N |
| Blood disease (anemia) | Y | N |
| Blood thinners (Coumadin) | Y | N |
| Ever had blood transfusion | Y | N |
| Bone or Joint Problems | Y | N |
| Arthritis | Y | N |
| Neck or back pain | Y | N |
| Joint replacement (knee,hip,etc) | Y | N |
| Taking Bisphosphonates (Fosamax) | Y | N |
| Cancer/Tumor | Y | N |
| Current Chemotherapy | Y | N |
| Chemical Dependency | Y | N |
| Do you smoke | Y | N |
| Do you drink alcohol | Y | N |
| Street/illegal drugs | Y | N |
| Diabetes | Y | N |
| Thirsty or dry mouth | Y | N |
| Kidney Dialysis | Y | N |
| Take Insulin | Y | N |
| Fainting Spells, Seizures | Y | N |
| Epilepsy | Y | N |
| Vertigo | Y | N |

| | Yes | No |
|---|---|---|
| Glaucoma | Y | N |
| Heart Problems | Y | N |
| Chest pain/Angina | Y | N |
| High Blood Pressure | Y | N |
| Low Blood Pressure | Y | N |
| Heart Murmur | Y | N |
| Heart Valve Problem | Y | N |
| Rheumatic fever | Y | N |
| Heart Surgery/Procedure | Y | N |
| Pacemaker | Y | N |
| Taking heart medicine | Y | N |
| Taking Baby Aspirin daily | Y | N |
| Hepatitis, Jaundice | Y | N |
| Liver problems | Y | N |
| Herpes Simplex 1 or 2 | Y | N |
| HPV | Y | N |
| HIV/AIDS | Y | N |
| Intestinal Problems | Y | N |
| Ulcers | Y | N |
| Difficulty taking meds | Y | N |
| Latex Sensitivity | Y | N |
| Lupus | Y | N |
| Psychiatric Care | Y | N |
| Respiratory Disorders | Y | N |
| COPD | Y | N |
| Stroke | Y | N |
| Thyroid Disease | Y | N |
| Women: Pregnant or nursing | Y | N |

Any condition or problem not listed that you think we should know about?

_____

_____

_____

**DENTAL AND MEDICAL HISTORY UPDATE**

Your information will need to be updated on paper every 24 months. Each time you return to our office we will update your information verbally. Please let us know if anything ever changes with your medical history or medications you are taking.

Please initial:

_____ I have reviewed my **Patient Information** form this office has on file and I agree that everything is correct and current.

_____ There are changes to my Patient Information form:

_____
_____
_____

_____ I have reviewed my **Dental Health History** form this office has on file and I agree that everything is correct and current.

_____ There are changes to my Dental Health History form:

_____
_____
_____

_____ I have reviewed my **Medical Health History** form this office has on file and I agree that everything is correct and current.

_____ There are changes to my Medical Health History form:

_____
_____
_____

During the past 12 months, have you taken any of the following?

| | | | | | |
|---|---|---|---|---|---|
| Antibiotics…….. | Y | N | Aspirin……. | Y | N |
| Blood thinners……. | Y | N | High blood pressure meds…… | Y | N |
| Tranquilizers/Sedatives……. | Y | N | Insulin, Orinase……. | Y | N |
| Nitroglycerin……. | Y | N | Digitalis or heart medicine…… | Y | N |
| Steroids/Cortisone…… | Y | N | Natural remedies…… | Y | N |

Allergies/Reactions/Hospitalizations:

_____
_____
_____

Patient Signature:_____ Date: _____