

YOUR PERFECT SMILE
Cosmetic and Family Dentistry
1939 Lawrence Road Kemah, Texas 77565
Telephone: (281) 538-9300

Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ SS # _____ DL # _____
Last Name First Name Middle Initial
Address _____ E-mail _____
City _____ State _____ Zip _____
Sex M F Age _____ Birthdate _____
 Married Widowed Single Minor
 Separated Divorced Partnered for _____ years
Patient Employer/School _____ Occupation _____
Employer/School Address _____ Employer/School Phone (____) _____
Whom may we thank for referring you? _____
In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial
Relation to Patient _____ Birthdate _____ Soc. Sec. # _____
Address (If different from patient's) _____ Phone (____) _____
City _____ State _____ Zip _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Business Phone (____) _____
Insurance Company _____
Contract # _____ Group # _____ Subscriber # _____
Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No
Subscriber Name _____ Birthdate _____ Relation to patient _____
Address (If different from patient's) _____ Phone (____) _____
City _____ State _____ Zip _____
Subscriber Employed by _____ Business Phone (____) _____
Insurance Company _____ Soc. Sec. # _____
Contract # _____ Group # _____ Subscriber # _____
Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Dr. _____ Name of Insurance Company(ies) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for the related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian, or Personal Representative

Date

Please print name of Patient, Parent, Guardian, or Personal Representative

Relationship to Patient

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MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine), and Redux (dexfenfluramine.) Yes No

List any operations and dates _____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____

(Women) Are you pregnant/trying to get pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check (✓) if you have or have had any of the following:

- | | | |
|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Parathyroid Disease |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Renal Dialysis |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Herpes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Thyroid Problems/Disease |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Problems/Disease | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Liver Problems/Disease | <input type="checkbox"/> Venereal Disease/STD |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Lung Disease | |

MEDICATIONS

List medications you are currently taking:

Pharmacy Name _____

Phone (____) _____

ALLERGIES

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Barbiturates (Sleeping pills) | <input type="checkbox"/> Latex _____ |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Local Anesthetic | _____ |
| <input type="checkbox"/> Penicillin | |

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____

DENTAL HISTORY

Reason for today's visit _____

Date of last dental care _____ Date of last dental X-rays _____

Previous Dentist _____

Address _____

Have you ever been told that you require an antibiotic prior to any medical or dental procedures? Yes No

Are you allergic to the latex in gloves? Yes No

Do you have frequent head, neck, or back pain? Yes No

Do you normally get fever blisters/cold sores? Yes No

Check (✓) if you have had problems with any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss? _____ How often do you brush? _____

SIGNATURE

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Date _____ Signature _____