

WELCOME

The benefits of a happy, healthy smiles are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

J Tim Rainey, D.D.S., M.A.G.D. • 606 Osage • Refugio, TX. 78377 (361)526-4695

Patient Name: _____ Date of Birth: _____ Age: _____

□ Male □ Female Social Security: _____ Email Address: _____
Last First M Mr. Mrs. Ms Dr

Address: _____ City: _____ St: _____ Zip: _____

Mailing Address: _____ City: _____ St: _____ Zip: _____

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

Spouse or Parent/Guardians: _____ Phone: _____

Whom may we thank for referring you to our office?: _____

How did you hear about our office?: Newspaper? Web site? Ad? Other? _____

In the event of an emergency – List person who we should contact?

His/Her Name: _____ Relationship to Patient: _____

Home Ph#: _____ Work #: _____ ext: _____ Cell #: _____

Responsible Party

Name of person responsible for this account: _____ Relationship: _____

Address: _____ City: _____ St _____ Zip _____

Date of Birth: _____ Social Security: _____ Employer? _____

Home Ph#: _____ Work #: _____ ext: _____ Cell #: _____

Insurance Information

Primary Insurance Dental Coverage? Yes No Orthodontic Coverage? Yes No Medical Coverage? Yes No

Insurance Co. Name: _____ Phone#: _____ Group# _____

Insured Name: _____ Insured's Social Security #: _____

Insured's Birthdate: _____ Relationship: _____ Phone #: _____

Insured's Employer: _____ Address: _____

Secondary Insurance Dental Coverage? Yes No Orthodontic Coverage? Yes No Medical Coverage? Yes No

Insurance Co. Name: _____ Phone#: _____ Group# _____

Insured Name: _____ Insured's Social Security #: _____

Insured's Birthdate: _____ Relationship: _____ Phone #: _____

Insured's Employer: _____ Address: _____

Dental History

Why have you come to the dentist today? _____

Are you currently in pain? Yes No
 Do you require antibiotics before dental treatment? Yes No
 Your current dental health is Good Fair Poor
 Do you floss daily? Yes No Brush daily? Yes No
 Type of bristles on your toothbrush? Hard Medium Soft
 Do your gums ever bleed? Yes No Ever itch? Yes No
 Have you ever had periodontal disease? Yes No
 Are your teeth sensitive to heat, cold, or anything else? _____
 Do you have mobility in your teeth? Yes No

Do you still have wisdom teeth? Yes No
 Do you brux, grind or clench your teeth? (circle one) Yes No
 Do you consume carbonated drinks? Yes No Number per day? _____

Previous/Present Dentist: _____ Last visit date: _____

Date of last full mouth set of xrays or panoramic film? _____
 Would you like fresher breath? Yes No Whiter teeth? Yes No
 Are you happy with the way your smile looks? Yes No

If not, what would you change? _____

Medical History

Do you have a personal physician? Yes No

Physician's Name: _____

Address: _____
 Street

City _____ State _____ Zip _____
 Phone #: _____ Date of last visit: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

Do you smoke or use tobacco in any other form? Yes No
 Have you ever taken Phen-Fen, Redux or Pondimin? Yes No

For Women: Are you taking birth control pills? Yes No
 Are you pregnant? Unsure Yes No

Week #: _____ Are you nursing? Yes No

OB/GYN Name: _____ PH #: _____

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Chicken Pox	Y N Glaucoma	Y N Kidney Problems	Y N Seizures
Y N Alcohol Abuse	Y N Colitis	Y N Hay Fever	Y N Liver Disease	Y N Shingles
Y N Alzheimer's Disease	Y N Congenital Heart Defect	Y N Headaches/Migraines	Y N Low Blood Pressure	Y N Sickle Cell Disease
Y N Anemia	Y N Diabetes	Y N Heart Attack/ Surgery	Y N Lupus	Y N Sinus Problems
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Murmur	Y N Mitral Valve Prolapse	Y N Steroid Therapy
Y N Artificial Bones/ Joints	Y N Drug Abuse	Y N Heart Trouble/ Disease	Y N Pacemaker	Y N Stroke
Y N Artificial Valves	Y N Emphysema	Y N Hemophilia	Y N Persistent Cough	Y N Thyroid Problems
Y N Asthma	Y N Epilepsy	Y N Hepatitis A, B, C	Y N Psychiatric Problems	Y N Tonsillitis
Y N Blood Transfusion	Y N Ever Hospitalized	Y N Herpes	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Cancer	Y N Fainting Spells	Y N High Blood Pressure	Y N Rheumatic Fever	Y N Ulcers
Y N Chemotherapy	Y N Fever Blisters	Y N HIV +/- AIDS	Y N Scarlet Fever	Y N Venereal Disease

Please list any serious medical conditions(s) that you have experienced: _____

Are you taking any prescription/ over the counter drug? Yes No If yes, please list each one: _____

Any conditions related to your _____ Heart _____ Joint Replacement That may require pre medication for dental treatment? _____

Have you had any Surgeries? Yes No If yes, Date: _____ Please explain _____

Are you allergic to any of the following?

<input type="checkbox"/> Acrylic	<input type="checkbox"/> Barbiturates	<input type="checkbox"/> Dental Anesthetics	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Jewelry/Metals
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Latex	<input type="checkbox"/> Sedatives	<input type="checkbox"/> Tetracycline

Please list anything additional that causes allergic reactions: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Payment is due in full at time of treatment
 Unless prior arrangements have been approved

 Signature Date

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Our office is committed to meeting or exceeding the standards of _____
 Infection control mandated by OSHA, the CDC and the ADA Signature Date