Welcome!

Delaney Family Dental
1705 S Fort Hood #102
Killeen TX. 76542

Phone # 254-618-5657
Fax # 254-449-8033

Patient Information

Date_____

Section I:

Name: _____ I prefer to be called: _____
Address: _____City:_____State:_____Zip:_____
Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____
Date of Birth: _____ Social Security Number: _____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Spouse or Parent's Name: _____ Work Phone_____
Whom may we thank for referring you?
_____
Person to contact in case of emergency_____ Phone_____
Email Address_____
We do send out reminders as a courtesy via **text** or **email** only if you sign into the program.

Section II **Responsible Party**

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name: _____ SSN#_____
Address: _____
City: _____ State: _____ Zip: _____ Phone: (____) _____
Employer_____ Work Phone (____) _____

Section III **Insurance Information**

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer: _____ Work Phone: (____) _____
Address of Employer: _____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address: _____ INS Co. Phone: _____
DO YOU HAVE ANY ADDIONAL INSURANCE? ☐ Yes ☐ No

The above information is true. I authorize my insurance benefits be paid directly to Dr. Delaney. ***I understand that I am financially responsible for any balance. Any balances past due in excess of thirty days are subject to further legal action.*** *I am also aware of the $75.00 no show or late cancelation fee. I also authorize Delaney Family Dental or insurance company to release any information required to process my claim. By signing this form I am also willingly giving Delaney Family Dental the consent to treatment as they deem necessary.*

Patient signature: Date:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
If female are you pregnant:		**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Allergies		

List any medical problems that other doctors have diagnosed

Have you ever had a blood transfusion?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain.

☐ Heart Disease	☐ Tuberculosis	☐ Asthma
☐ Heart Murmur	☐ Anemia	☐ AIDS
☐ Mitral Valve Prolaps	☐ Leukemia	☐ HIV Positive
☐ High Blood Pressure	☐ Kidney Problems	☐ Hepatitis
☐ Low Blood Pressure	☐ Diabetes	☐ Other pain/discomfort:
☐ Arthritis	☐ Excessive Bleeding	

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.

Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	# Of cups/cans per day?
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?		How many drinks per week?		
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever been given street drugs with a needle by you or anyone else?			☐ Yes	☐ No