

**CHRISTOPHER L. BARNES, D.D.S.**  
**670 W ARAPAHO RD., SUITE 1**  
**RICHARDSON, TEXAS 75080**  
**972.783.0990**

Date \_\_\_\_\_ Preferred to be called \_\_\_\_\_

Legal Name \_\_\_\_\_  Female  Male

Home Address \_\_\_\_\_

(City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_  Single  Married  
 Divorced  Widowed

Home# \_\_\_\_\_ DL # \_\_\_\_\_

Work# \_\_\_\_\_ Cell# \_\_\_\_\_ Pager# \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_

**SPOUSE INFORMATION**

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Work # \_\_\_\_\_ Cell \_\_\_\_\_ Pager# \_\_\_\_\_

**Person responsible for Account** Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Home# \_\_\_\_\_ Work# \_\_\_\_\_

**INSURANCE**

Dental Coverage?  Yes  No Insurance Co Name \_\_\_\_\_

Address \_\_\_\_\_

Insurance Co Phone# \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber# \_\_\_\_\_

Insured's Name \_\_\_\_\_ Employer \_\_\_\_\_

Insured's Birthdate \_\_\_\_\_ Insured's SS# \_\_\_\_\_ Relationship \_\_\_\_\_

Whom may we THANK for referring you \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

Previous / Present Dentist \_\_\_\_\_ Last visit date \_\_\_\_\_

(Please Circle)

Purpose of visit \_\_\_\_\_ Date of last complete dental x-rays \_\_\_\_\_

**DENTAL HISTORY**

Are you currently in pain?	Yes	No	Sensitive to hot	Yes	No	
Bleeding or sore gums	Yes	No	Sensitive to cold	Yes	No	
Unpleasant taste/bad breath	Yes	No	Sensitive to sweets	Yes	No	
Burning tongue/lips	Yes	No	Sensitive to pressure	Yes	No	
Frequent blisters/lips/mouth	Yes	No	Food Impaction	Yes	No	
Ortho treatment (braces)	Yes	No	Clenching/Grinding	Yes	No	
Biting cheeks /lips	Yes	No	Shifting of teeth	Yes	No	
Clicking/popping jaw	Yes	No	Change in bite	Yes	No	
Difficulty opening closing jaw	Yes	No	Loose teeth	Yes	No	
Have you ever had a serious/difficult problem associated with dental treatment				Yes	No	
Do you require antibiotics before dental treatment?		Yes	No			
Does dental treatment make you nervous?		Yes	No			
Have you ever been treated for periodontal disease?		Yes	No			
Do you use the following?						
Brush	Yes	No	How often?	_____		
Dental Floss	Yes	No	Toothbrush is:	Soft	Medium	Hard
Fluoride Rinse	Yes	No				
Other	_____					

**Payment is due in full at the time of treatment**  
unless prior arrangements have been approved.

We gladly accept payment by cash, check, Mastercard, Visa, Discover and CareCredit. I understand that I am responsible for payments of services rendered and also responsible for paying deductibles and any amount that my insurance does not cover. I understand that I am responsible for all costs of dental treatment. I authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Our office is HIPAA Compliant and is committed to exceeding the standards of infection control mandated by OSHA, the CDC and the ADA. Thank you for filling out this form completely. If you have any questions at any time please ask us.

**CHRISTOPHER L. BARNES, D.D.S.**  
**670 W ARAPAHO RD., SUITE 1**  
**RICHARDSON, TX 75080**  
**972.783.0990**

**MEDICAL HISTORY**

Name \_\_\_\_\_ Date \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Do you have a personal physician?  Yes  No Date of last checkup \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone# \_\_\_\_\_

Are you currently under the care of a physician?  Yes  No Please explain \_\_\_\_\_

Your current physical health is:  Good  Fair  Poor

Do you smoke or use tobacco in any other form?  Yes  No

Have you had any metal rods, pins or implants?  Yes  No

Please explain \_\_\_\_\_

**\*\*PLEASE ANSWER BY CIRCLING YES (Y) OR NO (N) FOR EACH QUESTION.**

Y	N	Abnormal Bleeding	Y	N	Herpes/Fever Blisters
Y	N	Alcohol / Drug Abuse	Y	N	High Blood Pressure
Y	N	Arthritis	Y	N	HIV+/AIDS
Y	N	Artificial Bones/Joints	Y	N	Hearing Loss
Y	N	Artificial Heart valves	Y	N	Intestinal Problems
Y	N	Asthma or Hay Fever	Y	N	Kidney Problems
Y	N	Anemia/Bulimia	Y	N	Liver Disease
Y	N	Cancer/Chemotherapy	Y	N	Low Blood Pressure
Y	N	Colitis	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Neurological Disease
Y	N	Diabetes	Y	N	Pacemaker
Y	N	Family History of Diabetes	Y	N	Psychiatric Treatment
Y	N	Emphysema	Y	N	Radiation Treatment
Y	N	Epilepsy or Seizures	Y	N	Rheumatic Fever/ Heart Disease
Y	N	Fainting Spells	Y	N	Shunts/Stints
Y	N	Frequent Headaches	Y	N	Stroke
Y	N	Glaucoma	Y	N	Shingles
Y	N	Heart Murmur	Y	N	Sinus Problems
Y	N	Heart Surgery	Y	N	Sexually Transmitted Disease
Y	N	Hemophilia	Y	N	Thyroid Problems
Y	N	Hepatitis or Liver Disease	Y	N	Tuberculosis
Y	N	Heart Disease Detected at Birth	Y	N	Ulcers

Please list any serious medical condition(s) \_\_\_\_\_

Are you ALLERGIC to any of the following?

Y	N	Aspirin	Y	N	Erythromycin
Y	N	Codeine	Y	N	Latex
Y	N	Tetracycline	Y	N	Dental Anesthetics
Y	N	Penicillin	Y	N	Sulfa Drugs

Other Allergies \_\_\_\_\_

Are you taking any of the following?

Y	N	Antibiotics	Y	N	Tranquilizers
Y	N	Blood Thinners	Y	N	Insulin/other diabetes drugs
Y	N	Blood Pressure Medication	Y	N	Recreational Drugs
Y	N	Thyroid Medication	Y	N	Digitalis/other heart medication
Y	N	Cortisone/Steroids	Y	N	Nitroglycerin
Y	N	Antihistamines/Allergy Medications	Y	N	Aspirin

Please list name of medication and dosage

1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_  
5. \_\_\_\_\_

**For Women**

Are you taking birth control pills?    Yes    No  
Are you pregnant?                            Yes    No  
Are you nursing?                              Yes    No

**EMERGENCY CONTACT NEIGHBOR OR RELATIVE NOT LIVING WITH YOU**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Home# \_\_\_\_\_ Work \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Cell \_\_\_\_\_

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 of confidence and it is my responsibility to inform this office of any changes in my medical status. I will not hold my dentist or any other member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Name of person completing form (if different from the patient) and relation to patient: \_\_\_\_\_