

# Summer Hill Dental

19750 State Highway 46 W., Suite 105  
Spring Branch, TX 78070

Thank you for visiting Summer Hill Dental. We want your visit to be pleasant and comfortable. Please help us by completing this form.

## Patient Information

Name \_\_\_\_\_  
LAST FIRST MIDDLE INITIAL NICKNAME

Address \_\_\_\_\_  
STREET

CITY STATE ZIP

Employer \_\_\_\_\_ Drivers License \_\_\_\_\_

Birth date \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Phone: Home (\_\_\_\_) \_\_\_\_\_ Social Security # \_\_\_\_\_

Work (\_\_\_\_) \_\_\_\_\_ May we contact you at work?  Yes  No

Mobile(\_\_\_\_) \_\_\_\_\_  Male  Female

E-mail address \_\_\_\_\_

Emergency: Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

## Insurance

### Primary Dental Carrier

Subscriber Name \_\_\_\_\_ Social Security # \_\_\_\_\_ DOB \_\_\_\_\_

Employer \_\_\_\_\_ Insurance Co. \_\_\_\_\_

Insurance Co. Phone # \_\_\_\_\_ Group # \_\_\_\_\_

Relation to patient \_\_\_\_\_

### Secondary Dental Carrier

Subscriber Name \_\_\_\_\_ Social Security # \_\_\_\_\_ DOB \_\_\_\_\_

Employer \_\_\_\_\_ Insurance Co. \_\_\_\_\_

Insurance Co. Phone # \_\_\_\_\_ Group # \_\_\_\_\_

Relation to patient \_\_\_\_\_

### Insurance Authorization Statement (Sign & Date)

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 and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

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

## If Patient is Under 18

Responsible Party \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Address \_\_\_\_\_  
STREET

CITY STATE ZIP

Telephone (\_\_\_\_) \_\_\_\_\_

## Other Information

How did you hear about us? \_\_\_\_\_

What was the reason for today's visit? \_\_\_\_\_

Do you love your smile? \_\_\_\_\_

Is there anything you would like to change? \_\_\_\_\_

Why did you leave your last dentist? \_\_\_\_\_

What did you like most about your last dentist? \_\_\_\_\_

## Medical History and Information

### Conditions

- Abnormal Bleeding
- Alcohol Abuse
- Allergies
- Anemia
- Angina Pectoris
- Arthritis
- Artificial Heart Valve
- Asthma
- Blood Transfusion
- Cancer
- Chemotherapy
- Colitis
- Congenital Heart Defect
- Diabetes
- Difficulty Breathing
- Drug Abuse
- Emphysema
- Epilepsy
- Facial Surgery
- Fainting Spells
- Fever Blisters
- Frequent Headaches
- Glaucoma
- HIV+ Aids
- Heart Attack

- Heart Murmur
- Heart Surgery
- Hemophilia
- Hepatitis A
- Hepatitis B
- Hepatitis C
- High Blood Pressure
- Joint Replacement
- Kidney Problems
- Liver Disease
- Low Blood Pressure
- Mitral Valve Prolapse
- Pace Maker
- Psychiatric Problems
- Radiation Therapy
- Rheumatic Fever
- Seizures
- Sexually Transmitted Disease
- Shingles
- Sickle Cell Disease
- Sinus Problems
- Stroke
- Thyroid Problems
- Tuberculosis
- Ulcers

### Allergies

- Aspirin
- Codeine
- Dental Anesthetics
- Erythromycin
- Latex
- Metals
- Penicillin
- Sulfa
- Tetracycline

Other \_\_\_\_\_  
\_\_\_\_\_

Y N

- Do you Smoke  
or use Tobacco?

If Female

Y N

- Are you taking Birth  
Control Pills?  
  Are you pregnant?  
If yes, # of weeks \_\_\_\_\_  
  Are you Nursing?

Please list any medications  
you are currently taking: \_\_\_\_\_  
\_\_\_\_\_

## Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

\_\_\_\_\_  
PATIENTS SIGNATURE

\_\_\_\_\_  
DATE

If patient is a child or requires a guardian:

\_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE