

Your Perfect Smile Cosmetic & Family Dentistry
1939 Lawrence Rd. Kemah, Texas 77565

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? _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ 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

DENTAL HISTORY

Reason for today's visit _____

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

Previous Dentist _____ Address _____

Do you currently have a nightguard or other kind of oral appliance? Yes No

If yes, do you wear your nightguard or appliance as instructed? Yes No

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

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 _____

MEDICAL HISTORY

Name of Current Physician _____ 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

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? Yes No

List any operations or head/neck injuries _____

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

MEDICATIONS

List medications you are currently taking:

Pharmacy Name _____

Phone (____) _____

Do you use controlled substances? Yes No

ALLERGIES

Aspirin Sulfa

Barbiturates (Sleeping pills) Latex _____

Codeine Other _____

Local Anesthetic _____

Penicillin Are you on a special diet? Yes No

Have you ever had any serious illness or condition not listed above? Yes No If yes: _____

List any medical conditions that run in your family: _____

SIGNATURE

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Date _____ Signature _____