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

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 □ 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 Murmer	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 Tonsilitis
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?

□Acrylic	□Barbiturates	□Dental Anesthetics	□ Penicillin	□Sulfa Drugs	□Jewelry/Metals
□Aspirin	□Codeine	□Erythromycin	□ Latex	□Sedatives	□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

Patient Form 11/2007