209A N. Ridgeway Drive • Cleburne, TX 76033 • Phone: (817) 641-4488 • Fax: (817) 645-3599

Welcome to Our Office

Thank You For Completing The Following Confidential Information

Patient Information

Patient's Name ______________________________ Preferred Name ____________
First M.I, Last

Address ______________________________ E-mail ____________
Street City State Zip

Home Phone ____________ Work Phone ____________ Cell Phone ____________

Sex: ❑ Male ❑ Female Marital Status ________ Date of Birth _____/_____/_____ Social Security# ____________

If minor, please list parent's names: Father ____________ Mother ____________

Account Information

Who will be responsible for this account? ❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other ____________

Name ______________________________
First M.I, Last

Address ______________________________ E-mail ____________
Street City State Zip

Date of Birth _____/_____/_____ Social Security# ____________ Driver's License# ____________

Home Phone ____________ Work Phone ____________ Cell Phone ____________

Employer ______________________________ Current Position ____________

Dental Insurance Information

Carrier Name ____________ Group #____________ ID #____________

Carrier Address______________________________ Phone ____________

Policy Holder's Name ______________________________
First M.I, Last

Address ______________________________ E-mail ____________
Street City State Zip

Date of Birth _____/_____/_____ Social Security# ____________ Driver's License# ____________

Home Phone ____________ Work Phone ____________ Cell Phone ____________

Policy Holder's Employer ______________________________ Current Position ____________

Emergency Contact Information

In case of emergency whom should we contact? ______________________________ Relationship____________

Address______________________________ Phone ____________
Street City State Zip

Getting to Know You

Why did you select our office? ______________________________

Whom may we thank for referring you? ______________________________

Date and reason for your last dental visit? ______________________________ Dentist ____________

Reason for today's visit? ______________________________

I authorize the release of any information relating to any insurance claims. I understand that payment is my obligation regardless of insurance or any other third party involvement. I understand it is my responsibility to pay any deductible amount, co-insurance or any other balance not paid for by my insurance company.

______________________________ ______________________________ ______/______/______
Signature of Patient (Parent or Guardian if minor) Relationship Date

MEDICAL HISTORY

Although dentists primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the care that you will receive. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

1. Name of Physician ____ Phone ________________________
2. Have there been any changes to your health in the last year? ❑ Yes ❑ No

   If Yes, please explain ____
3. Have you had any illness, operation or been hospitalized in the past five years? ❑ Yes ❑ No

   If Yes, please explain ____
4. Are you allergic to (i.e. itching, rash, swelling) or made sick by any drugs, medications, metals or latex? ❑ Yes ❑ No

   If Yes, please list ____
5. Check any of the following which you have had or have at present:

❑ Heart Disease or Attack	❑ Liver Disease	❑ AIDS or HIV
❑ Heart Murmur	❑ Hepatitis	❑ STD
❑ Heart Surgery	❑ Kidney Disease	❑ Abnormal Bleeding
❑ Prosthetic Heart Valve	❑ Diabetes	❑ Bruise easily
❑ Pacemaker	❑ Cancer	❑ Hemophilia
❑ High/Low Blood Pressure	❑ Chemotherapy	❑ Ulcers
❑ Rheumatic Fever	❑ Stroke	❑ Arthritis
❑ Lung Disease	❑ Epilepsy/Seizures	❑ Joint Replacement
❑ Asthma	❑ Glaucoma	❑ Jaw or TMJ Pain
❑ Tuberculosis (TB)	❑ Psychiatric Disorders	❑ Osteoporosis
❑ Shortness of Breath	❑ Alcohol/Drug Abuse	❑ Cortisone Treatment

6. Please list any disease, condition or problem not listed above ____________________________________

   ____
7. List all medications you are taking at this time ____

   ____

   ____
8. Have you ever taken bone density medications/bisphosphonates (i.e. Zometa, Aredia, Fosamax, Actonel)? ❑ Yes ❑ No
9. Do you use or have you ever used any form of tobacco? ❑ Yes ❑ No If Yes, what and for how long? ______________________
10. Do you use or have you ever used recreational (street) drugs? ❑ Yes ❑ No If Yes, please explain? ______________________
11. Do you ever wake up from sleep short of breath or do you snore? ❑ Yes ❑ No
12. Female Patients

    12a. Are you pregnant? ❑ Yes ❑ No If Yes, what month are you due? ________________ Are you nursing? ❑ Yes ❑ No

    12b. Name and phone number of your obstetrician ____

    12c. Are you currently taking any form of oral birth control? ❑ Yes ❑ No
13. Do you clench or grind your teeth? ❑ Yes ❑ No
14. Does your mouth feel dry? ❑ Yes ❑ No
15. Are any of your teeth sensitive to cold, hot, sweets or pressure? ❑ Yes ❑ No
16. Do you feel nervous about dental treatment? ❑ Yes ❑ No
17. How do you feel about the appearance of your teeth? ____
18. If you could change anything about your smile, what would you change? ________________________________

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I have made in the completion of this form.

____ ________________________________ ______/______/______

Signature of Patient (Parent or Guardian if minor) Relationship Date