



**Jack Shirley, D.D.S.**  
Restorative and Cosmetic Denistry

**Medical History**

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**If yes, please explain:**

- Are you under a physician's care now?  Yes  No \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No \_\_\_\_\_
- Are you currently taking any prescription drugs of any kind?  Yes  No \_\_\_\_\_
- Are you currently taking any nonprescription drugs of any kind?  Yes  No \_\_\_\_\_
- Are you taking, or have you taken, Phen-Fen, Redux, or Pondimin?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No \_\_\_\_\_
- Do you use tobacco?  Yes  No \_\_\_\_\_
- Women: Are you  Pregnant/Trying to get pregnant?  Nursing?  Taking oral contraceptives?

Are you allergic to any of the following?  
 Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  Other \_\_\_\_\_

Do you have, or have you had, any of the following?

AIDS/HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimer's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever*	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anaphylaxis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B or C	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Easily Winded	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hives or Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joint*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular Heartbeat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sjogrens Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting Spells/Dizzines	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Auto-immune disease (lupus, pemphilus)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fibromyalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spina Bifida	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach/Intestinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Proessure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breathing Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Limbs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Genital Herpe	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Jaw Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parathyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pains	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack/Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Organ Transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors or Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cold Sores/Fever Blisters	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Pacemaker*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Veneral Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Trouble/Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Weight Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yellow Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\* Condition may require medication

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

\_\_\_\_\_  
SIGNATURE OF PATIENT, PARENT, or GUARDIAN

\_\_\_\_\_  
DATE

**Jack Shirley, D.D.S.**  
Restorative and Cosmetic Denistry  
**Dental Information**

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**Please fill out the following information:**

- 1) What are some typical foods you eat between meals? \_\_\_\_\_
- 2) What types of beverages do you typically drink between meals? \_\_\_\_\_
- 3) How often do you chew or suck on hard candy, cough drops or mints? \_\_\_\_\_
- 4) Do you use fluoridated toothpaste?       Yes       No
- 5) Primary source of drinking water? (circle one)
 

City water, filtered	City water, unfiltered
Bottled water	Well water

**Do you have consistent problems with:**

- 6) Dry mouth / excessive thirst??       Yes       No
- 7) Sensitive teeth? (please circle any that are applicable)      Hot      Cold      Pressure      Sweets
- 8) Mouth odors / bad taste?       Yes       No
- 9) Cold sores / blisters / oral lesions       Yes       No
- 10) Are you aware of any swelling or lumps?       Yes       No
- 11) Sore, bleeding gums?       Yes       No
- 12) Loose teeth?       Yes       No
- 14) Difficulty chewing?       Yes       No
- 15) Food catches between teeth?       Yes       No
- 16) Teeth / fillings break frequently?       Yes       No
- 17) Clenching or grinding habits?       Yes       No
- 18) Do you hear popping, clicking or snapping sounds when you chew?       Yes       No
- 19) Do you have jaw pain?       Yes       No
- 20) Are you nervous about dental work?       Yes       No

**Payment Options**

For your convenience, we accept cash, personal checks, and major credit cards. Payment is expected at the time services are performed.

**Insurance**

We are out of network on ALL insurance plans. As a service to our patients, we will file your insurance. However, payment is due at the time of service. If filing becomes problematic, we reserve the right to discontinue this service. We remind you that your specific policy is an agreement between you and your insurance company. Please keep in mind that you are responsible for your total obligation.

It is important to be well informed regarding the extent of your insurance coverage. Every insurance carrier and employer is unique in the benefits they offer their employees; our staff does not know what services are covered in your plan. Please refer to your benefits manual and/or your insurance website to be familiar with your particular benefits. It is our stance that you are responsible to know your insurance benefits.

I have read the information about the office policy regarding payment and insurance filing and will comply fully.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Jack Shirley, D.D.S.**  
Restorative and Cosmetic Dentistry  
**CONSENT FOR USE AND DISCLOSURE  
OF HEALTH INFORMATION**

**SECTION A: PATIENT GIVING CONSENT**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Patient # \_\_\_\_\_ SocialSecurity# \_\_\_\_\_

**SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

**Jack Shirley, D.D.S.**  
7826 Louis Pasteur #103  
San Antonio, TX 78229  
210-615-8357 • Fax: 210-615-8359

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance of this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**SIGNATURE**

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment and health care operations.

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

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**REVOCACTION OF CONSENT**

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

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

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.  
Include completed Consent in the patient's chart.**

**Jack Shirley, D.D.S.**  
Restorative and Cosmetic Dentistry

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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\*You May Refuse to Sign This Acknowledgement\*

I, \_\_\_\_\_, have received a copy of this office's  
Notice of Privacy Practices.

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**For Office Use Only**

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We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but  
acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_