



8825 Bee Caves Rd.
Suite E
Austin, TX 78746

Patient # _____ -
SS#/SIN _____

Patient Information (CONFIDENTIAL)

Date _____

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State ____ Zip Code _____

Email _____ Cell Phone _____

Please circle: Minor Single Married Divorced Widowed Separated

Students: Name of School/College _____ City _____ State ____ Fulltime or Parttime

Patient or Parent/Guardian Employer _____ Work Phone _____

Business Address _____ City _____ State ____ Zip Code _____

Spouse or Parent/Guardian _____ Employer _____ Phone _____

Whom me we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Person Responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____ Financial Inst. _____

Employer _____ Work Phone _____ SS# _____

Are you currently a patient? YES NO

Please circle preferred method of payment: (Payment in full at each appointment)

Cash Personal Check Credit Card: VISA MasterCard I wish to discuss the office's payment policy

Insurance Information

Name of Insured _____ Relation to Patient _____

Birthdate _____ SS# _____ Date Employed _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State ____ Zip Code _____

Insurance Company _____ Group# _____ Policy ID# _____

Ins. Co. Address _____ City _____ State ____ Zip Code _____

How much is your deductible? _____ How much have you used? _____ Max annual benefit? _____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No		Yes	No
1. Are you under medical treatment now?.....	<input type="checkbox"/>	<input type="checkbox"/>	10. Are you wearing contact lenses?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?..... If yes, please explain _____	<input type="checkbox"/>	<input type="checkbox"/>	11. Are you allergic to or have you had any reactions to any of the following:		
3. Are you taking any medication(s), including non-prescription medicine?..... If yes, please list medications _____	<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetics (Novocain).....	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever taken Fen-Phen/Redux?.....	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or any other antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer meds with bisphosphonates?.....	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa Drugs.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you taken Viagra, Revatio, Cialis, or Levitra in the last 24 hours?.....	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you use tobacco?.....	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives.....	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you use controlled substances?.....	<input type="checkbox"/>	<input type="checkbox"/>	Iodine.....	<input type="checkbox"/>	<input type="checkbox"/>
			Aspirin.....	<input type="checkbox"/>	<input type="checkbox"/>
			Any Metals (nickel, mercury, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>
			Latex Rubber.....	<input type="checkbox"/>	<input type="checkbox"/>
			Other (Please List) _____		
			12. Do you have a persistent cough or throat clearing not associated with illness (more than 3 weeks)?.....	<input type="checkbox"/>	<input type="checkbox"/>
			13. Women Only:		
			a) Are you pregnant or think you are pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
			b) Are you nursing?.....	<input type="checkbox"/>	<input type="checkbox"/>
			c) Are you taking oral contraceptives?.....	<input type="checkbox"/>	<input type="checkbox"/>

9. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains.....	<input type="checkbox"/>	<input type="checkbox"/>
Heat Attacks.....	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded.....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles.....	<input type="checkbox"/>	<input type="checkbox"/>	Angina.....	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/Seizing.....	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy.....	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions.....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss.....	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement/Implant	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble.....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems...	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection.....	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Trans. Disease	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse...	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem.....	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Trouble/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		

Patient Dental History Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing?.....	<input type="checkbox"/>	<input type="checkbox"/>	8. Do you have frequent headaches?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Are your teeth sensitive to hot or cold liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you clench or grind your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you bite your lips or cheeks frequently?.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you feel pain to any of your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever had any difficult extractions in the past?.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any sores or lumps in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had any prolonged bleeding following extractions?.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had any head, neck or jaw injuries?.....	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you had any orthodontic treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever experienced any of the following problems in your jaw?			14. Do you wear dentures or partials?..... If yes, date of placement _____	<input type="checkbox"/>	<input type="checkbox"/>
Clicking.....	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?.....	<input type="checkbox"/>	<input type="checkbox"/>
Pain (joint, ear, side of face).....	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you like your smile?.....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing.....	<input type="checkbox"/>	<input type="checkbox"/>			
Difficulty in chewing.....	<input type="checkbox"/>	<input type="checkbox"/>			

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient/Guardian X _____ Date _____