333 North Allen Drive
Allen, Texas 75013
972.727.1901

PATIENT HISTORY

Please complete the following confidential information on both sides of this form.

Date: ___________________ Patient's Name: ____
First Middle Last

Nickname: _______________ DOB: ______________ SSN: ____________________________ DL#: ___________________

Patient Address : ____ City: _________________ State: ______ Zip: _______

Home Phone: ____________________________ Business Phone: _______________________ Cell: ____________________

Email: ____ Referred to us by: _______________________

Employer: ____ Occupation: ____________________________________

Emergency Contact Name and Phone#: ____

PERSON RESPONSIBLE FOR THE ACCOUNT

Name: ____ D.O.B.: _______________ SSN:_________________
First Middle Last

Address : ____ City: _________________ State: ______ Zip: _______

Employer: ____

INSURANCE INFORMATION

Name of insured: ____ D.O.B.: __________________ SSN: _________________

Employer: ____

Insurance Company: ________________________________ Phone Number: _________________ Group #: _______________

Signature required of assignment of benefits : X____

DENTAL HEALTH

1. Please state your chief concern: ____
2. Are you having pain of discomfort at this time? ❑ Yes ❑ No. If Yes, Please Describe: ________________________________
____
3. Date of Last Dental Visit? _______________ Name of Previous Dentist: _______________________ Phone: ______________
4. What is your normal routine for Cleaning your teeth? ___________________________________Frequency: _____________
5. Do you have an unpleasant odor or taste in your mouth? ❑ Yes ❑ No
6. Do your gums bleed when you brush or floss? ❑ Yes ❑ No
7. Have you had gum disease or Pyorrhea? ❑ Yes ❑ No
8. Do you have sensitivity to any of the following? ❑ Hot foods or liquids ❑ Sweets ❑ Pressure ❑ Biting
❑ Cold foods or liquids ❑ Sour food or liquids
9. Do you clench or grind your teeth during the day or night? ❑ Yes ❑ No
10. Have you had orthodontic treatment (braces)? ❑ Yes ❑ No
11. Are you happy with the appearance of your teeth? ❑ Yes ❑ No
12. Are you happy with the color of your teeth? ❑ Yes ❑ No
13. Do you feel nervous about having dental treatment? ❑ Yes ❑ No
14. Have you had a bad experience in the dental office? ❑ Yes ❑ No
15. Do you wear a partial or full denture? ❑ Yes ❑ No
16. Do you gag easily? ❑ Yes ❑ No
17. Do you snore or have sleep apnea? ❑ Yes ❑ No
18. Have you used nitrous oxide gas to help relax during previous dental treatments? ❑ Yes ❑ No Headphones ❑ Yes ❑ No
19. Please add anything you feel is important for the doctor to know: ____
____

MEDICAL HISTORY

Dr Reviewed ______

General Health ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Date of last complete physical? ________________ Findings: ________________________________

General Physician: ____

Address of physician: ______________________________ City: ______________ State: ______ Zip: _______

1. Are you currently under the care of a medical doctor? ❑ Yes ❑ No
   If Yes, state the name of the attending physician: ________________________________
   Address: ______________________________ City: ______________ State: ______ Zip: _______
2. What type of treatment are you receiving? ________________________________
3. Are you currently taking any prescription or over-the-counter medications? ❑ Yes ❑ No
   If Yes, please list and state reason:
   ____
   ____
4. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? (Including Penicillin, Novocaine, Codeine, food, etc.) ❑ Yes ❑ No If Yes, please list and describe:________________________
5. Have you been a patient in the hospital during the past three years? ❑ Yes ❑ No
   If Yes, please state reason and dates of stay:
   ____
6. Have you been under the care of a medical doctor during the past three years? ❑ Yes ❑ No
   If Yes, please state name of attending physician and reason: ________________________________
7. Have you had any diagnostic tests in the past two years? ❑ Yes ❑ No
   If Yes, please list test and results:________________________________
8. Indicate which of the following you have had or have at the present. Please check yes of no to each item.

	❑ Yes	❑ No	When
Heart Failure	❑	❑	_______
Heart Disease or Attack	❑	❑	_______
High blood Pressure	❑	❑	_______
What is your normal BP? _______________			
Heart Murmur/MVP	❑	❑	_______
Rheumatic Fever	❑	❑	_______
Congenital Heart Lesions	❑	❑	_______
Scarlet Fever	❑	❑	_______
Artificial Heart Valve	❑	❑	_______
Heart Pacemaker	❑	❑	_______
Date Placed: _________________________			
Heart Surgery	❑	❑	_______
Artificial Joints (Hip, knee, etc.)	❑	❑	_______
Anemia	❑	❑	_______
Stroke	❑	❑	_______
List any impairments: _____________________ ___________________________________			
Kidney Trouble	❑	❑	_______
Gall Bladder	❑	❑	_______
Stomach Ulcers	❑	❑	_______
Emphysema	❑	❑	_______
Chronic Cough	❑	❑	_______

	Yes	No	When
Pneumonia	❑	❑	_______
Tuberculosis (TB)	❑	❑	_______
Have you taken INH?	❑	❑	_______
Asthma	❑	❑	_______
Exertion Asthma	❑	❑	_______
Sinus Trouble	❑	❑	_______
Allergies (seasonal)	❑	❑	_______
Hives	❑	❑	_______
Hay Fever	❑	❑	_______
Tested for HIV (AIDS)?	❑	❑	_______
Test Date(s): ___________________________ ❑Positive ❑Negative ❑Unknown			
AIDS	❑	❑	_______
ARC	❑	❑	_______
AZT Medications	❑	❑	_______
Thyroid condition	❑	❑	_______
Radiation/Cobalt Therapy	❑	❑	_______
Chemotherapy ❑Cancer ❑Leukemia	❑	❑	_______
Arthritis	❑	❑	_______
Therapy: ______________________________			
Rheumatism	❑	❑	_______
Hepatitis A (infectious)	❑	❑	_______
Hepatitis B (serum)	❑	❑	_______

	Yes	No	When
Hepatitis C	❑	❑	_______
Liver disease	❑	❑	_______
Yellow Jaundice	❑	❑	_______
Surface Antigens? ❑Positive ❑Negative			
Blood Transfusion	❑	❑	_______
Date: ________________________________			
Drug Addiction	❑	❑	_______
Alcoholism	❑	❑	_______
Hemophilia	❑	❑	_______
Bleeding disorders	❑	❑	_______
Venereal Disease (Syphilis, Gonorrhea, Herpes)	❑	❑	_______
Cold Sores/Fever Blisters	❑	❑	_______
Epilepsy or Seizures	❑	❑	_______
Fainting or Dizzy Spells	❑	❑	_______
Psychiatric Treatment	❑	❑	_______
Sickle Cell Disease	❑	❑	_______
Bruise Easily	❑	❑	_______
Glaucoma	❑	❑	_______
Pain in jaw joint (TMJ)	❑	❑	_______
Multiple Sclerosis	❑	❑	_______
Organ Replacement	❑	❑	_______
Diabetes	❑	❑	_______
How controlled? ______________________			

9. Do you use tobacco ❑ Yes ❑ No If Yes, What type? ___________________________ Frequency? _______________
   Have you tried Habitrol or other methods for smoking cessation? ❑ Yes ❑ No
10. Do you become very tired or develop chest pain when walking or walking up stairs? ❑ Yes ❑ No
11. Do you have special dietary needs? ❑ Yes ❑ No
12. Has your medical doctor ever said you have a cancer or tumor? ❑ Yes ❑ No
13. Do you have any disease, condition or problem not listed? ❑ Yes ❑ No
14. Have you been advised by a physician that you require pre-medication for dental treatment? ❑ Yes ❑ No
15. Do you wear contact lenses? ❑ Yes ❑ No Glasses? ❑ Yes ❑ No

FOR WOMEN ONLY:

Are you pregnant ❑ Yes ❑ No If yes, when is your due date? _________________ Are you Nursing? ❑ Yes ❑ No

Are you taking birth control pills? ❑ Yes ❑ No Are you taking hormones? ❑ Yes ❑ No

Are you in or have you completed menopause? ❑ Yes ❑ No

I understand and the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient/Responsible Party Signature ____Date: ______________________