

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Correct answers to the following questions will allow us to treat you on a more individual basis, providing the care appropriate to your particular needs. Your answers are for our records only and will be held confidential.

Patient 1	Informa	ation
Today's Date:		_
Name:FIRST	MI	LAST
I prefer to be called:		
Birthdate://		
Home Address:		
		(Apt/Condo #)
(City)	(State)	(ZIP)
□Single □Married	□Divorced	■ Widowed
Home #:	Cell or Other #:	
Wk #: Ex	xt: DLi	#:
Email:		
Employer:		
Work Address:		
How long there?	Occupation:	
Where & when are the best time	es to reach you?	·
Other family members seen by	us:	
Previous or Present Dentist:		
How were you referred?(A	d, Church, Yellow Page	s, Friend's Name)

Dental Insurance  Primary Dental Insurance
Insurance Co. Name:
Insurance Co. Address:
Insurance Co. Phone #:
Group # (Plan #):
Insured's Name:Relationship:
Insured's Birthdate:/ Insured's ID#:
Insured's Employer:
paperwork for direct reimbursement to you.  Secondary Dental Insurance
Insurance Co. Name:
Insurance Co. Address:
Insurance Co. Phone #:
Group # (Plan #):
Insured's Name:Relationship:
Insured's Birthdate:/ Insured's ID#:
Insured's Employer:

## Spouse/Parent Information Their Name: \_\_\_\_\_ Employer: \_\_\_\_\_ Wk #: \_\_\_\_ Ext: \_\_\_\_ SS#: \_\_\_\_ Birthdate: \_\_\_\_/ \_\_\_/ DL#: \_\_\_\_



The Fine Art of Family & Cosmetic Dentistry

Additional 1	Information
Person Responsible for Account:	
Wk #: Ext:	Home #:
Address:	
Relationship:	SS#:
Employer:	_ DL#:(Required)
In the event of an emergency, is the	ere someone who lives near you
or works with you that we should co	ontact?
Their Name:	Relationship:
Work #:	Home #:

102 Flag Lake Dr., Suite C, Lake Jackson, TX 77566 (979) 297-1201 Fax (979) 297-6226

Phys	sica	ın's Name:						Phone:			
۹re ۱	you	taking any prescription/ov	er counte	er dr	ugs? ☐Yes ☐No For W	omer/	n: /	Are you taking birth co	ntrol pills	s?	☐ Yes ☐ No
Plea	se l	list each one:			Are yo	ou pre	egn	ant? ☐ Yes ☐ No V	Veek #:_		
					Have	you e	eve	r taken premedication	for a der	ntal	visit: Yes No
		Have	you eve	r ha	d any of the following dis	ease	es (	or medical problem	ns?		
Υ	Ν	Abnormal Bleeding / Hemop	hilia Y	N	Cancer	Υ	N	Mitral Valve prolapse	Υ	Ν	Psychiatric Problem
Υ	N	Anemia	Υ	Ν	Chemotherapy	Υ	Ν	Heart Murmur	Υ	Ν	Radiation Treatmer
Υ	N	Arthritis	Y	Ν	Diabetes	Υ	Ν	Pacemaker	Υ	Ν	Rheumatic Fever
Υ	N	Artificial Bones	Y	Ν	Drug / Alcohol Abuse			Heart Surgery	Y	N	Shingles
Υ	N	Artificial Joints	Y	Ν	Emphysema	Υ	Ν	Hepatitis A, B, C	Υ	Ν	Sinus Problems
Υ	N	Artificial Valves	Y	Ν	Epilepsy / Seizures / Fainting			High Blood pressure			Stroke
Υ	N	Asthma	Y	Ν	Glaucoma			Low Blood pressure			Tuberculosis (TB)
Υ	N	Difficulty Breathing	Y	Ν	Headaches Severe / Frequent			Kidney Problems			Ulcers
		Discoul This area	Υ	Ν	Heart Attack	Υ	Ν	HIV / AIDS	Y	Ν	Colitis
Y			Y ndition(s)	that	Heart Congenital Defect  you have ever had:			Hospitalized for any rea			
Y Plea	N ise I you Asp	Blood Transfusion  list any serious medical co  allergic to any of the follow pirin Y N Den	yndition(s) wing drug	that	you have ever had:  Y N Tetracycline			Y N Sulfa			er
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