FORT BEND DENTAL

Welcome! We are pleased that you have chosen us to care for your dental health. Please help us by taking a minute to fill out both sides of this form. We promise that all of this information will remain confidential.

Date: _____

PATIENT INFORMATION

Name: _____
(Last) (First) (Middle Initial) (Nickname)

Home Address: _____
(Street)

_____
(City) (State) (Zip)

Home Telephone: _____ Cell Phone: _____ Email: _____

Date of Birth: _____ Social Security Number: _____ Driver License No.: _____

Sex: ❑ Male ❑ Female Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widow

Emergency Contact Name and Number: _____ Relationship: _____
(someone not in your household)

Spouse's Name: _____ Spouse Daytime Phone: _____

Preferred Dentist: _____

Patient's Employer: _____

Employer's Address: _____
(Street) (City) (State) (Zip)

Business Phone: _____ Present Position: _____

Whom may we thank for referring you to us? _____

BILLING INFORMATION

Person Responsible for Bill: _____
(Last) (First) (Middle Initial)

Social Security Number: _____ Date of Birth: _____

Responsible Party's Address: _____
(Street)

_____ Relationship to Patient: _____
(City) (State) (Zip)

Responsible Party's Home Telephone: _____ Business Telephone: _____

Responsible Party's Employer: _____

Employer's Address: _____

INSURANCE INFORMATION

As a courtesy we will accept payment of benefits directly from your insurance company. Please fill this part out accurately and completely. The part of our fee that is not covered by insurance is due at the time of treatment.

Name of insurance company: _____

Address of insurance company: _____
(Street) (City) (State) (Zip)

Name of insured: _____ Employer: _____

Group number: _____ Social Security Number: _____

Date of Birth of Insured: _____ ID or Clock #: _____

Telephone Number of Insurance Company: _____

Do you have secondary insurance? ❑ Yes ❑ No If yes, please see a business associate.

MEDICAL HISTORY

PATIENT NAME: _____

Although dental personnel 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 dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ❍ Yes ❍ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ❍ Yes ❍ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ❍ Yes ❍ No If yes, please explain: _____

Are you taking any medications, pills or drugs? ❍ Yes ❍ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ❍ Yes ❍ No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ❍ Yes ❍ No

Are you on a special diet? ❍ Yes ❍ No

Do you use tobacco? ❍ Yes ❍ No

Do you use controlled substances? ❍ Yes ❍ No

Women: Are you
Pregnant/Trying to get pregnant? ❑ Yes ❑ No Taking oral contraceptives? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex ❑ Local Anesthetics ❑ Sulfa Drugs

❑ Other If yes, please explain _____

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

❑ AIDS/HIV Positive	❑ Cortisone Medicine	❑ Hepatitis A	❑ Rheumatic Fever
❑ Alzheimer's Disease	❑ Diabetes	❑ Hepatitis B or C	❑ Rheumatism
❑ Anaphylaxis	❑ Drug Addiction	❑ Herpes	❑ Scarlet Fever
❑ Anemia	❑ Easily Winded	❑ High Blood Pressure	❑ Shingles
❑ Angina	❑ Emphysema	❑ Hives or Rash	❑ Sickle Cell Disease
❑ Arthritis/Gout	❑ Epilepsy or Seizures	❑ Hypoglycemia	❑ Sinus Trouble
❑ Artificial Heart Valve	❑ Excessive Bleeding	❑ Irregular Heartbeat	❑ Spina Bifida
❑ Artificial Joint	❑ Excessive Thirst	❑ Kidney Problems	❑ Stomach/Intestinal Disease
❑ Asthma	❑ Fainting Spells/Dizziness	❑ Leukemia	❑ Stroke
❑ Blood Disease	❑ Frequent Cough	❑ Liver Disease	❑ Swelling of Limbs
❑ Blood Transfusion	❑ Frequent Diarrhea	❑ Low Blood Pressure	❑ Thyroid Disease
❑ Breathing Problem	❑ Frequent Headaches	❑ Lung Disease	❑ Tonsillitis
❑ Bruise Easily	❑ Genital Herpes	❑ Mitral Valve Prolapse	❑ Tuberculosis
❑ Cancer	❑ Glaucoma	❑ Osteoporosis	❑ Tumors or Growths
❑ Chemotherapy	❑ Hay Fever	❑ Pain in Jaw Joints	❑ Ulcers
❑ Chest Pains	❑ Heart Attack/Failure	❑ Parathyroid Disease	❑ Venereal Disease
❑ Cold Sores/Fever Blisters	❑ Heart Murmur	❑ Psychiatric Care	❑ Yellow Jaundice
❑ Congenital Heart Disorder	❑ Heart Pacemaker	❑ Radiation Treatments	
❑ Convulsions	❑ Heart Trouble/Disease	❑ Recent Weight Loss	
	❑ Hemophilia	❑ Renal Dialysis	

Have you ever had any serious illness not listed above? ❍ Yes ❍ No ❍ N/A _____

Comments: _____

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 (or 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