FUQUA
ADVANCED DENTAL

1422 Main Street, Suite 207 • Southlake, TX 76092
817.410.8765 • Fax: 817.410.8776
www.FuquaAdvancedDental.com

Patient's Name _____ Birthdate _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Sex: M or F Social Security # _____ Occupation _____

Employer or School _____ Length of Employment: _____ Work Phone _____

Email Address _____ Cell Phone _____

Person Responsible for Payment _____
Last First Middle

Address _____
Street City State Zip

Relationship to Patient _____ Social Security # _____ Birthdate _____

Driver's License # _____ Home Phone _____

Employer _____ Occupation _____ Work/Cell Phone _____

Patient's Spouses Name _____
Last First Middle

Spouses Employer _____

Occupation _____ Length of Employment: _____ Work/Cell Phone _____

DENTAL INSURANCE INFORMATION (need copy of card)

Insured's Name (employee) _____

Insured's Birthdate _____ Insured's Social Security # _____

Insured's Address (if different from above) _____

Insured's Employer _____ Work Phone _____

Name of Insurance _____ ID # _____ Group # _____

Insurance Address _____ Phone # _____

EMERGENCY INFORMATION

Local Friend or Relative not living with you _____

Complete Address _____

Phone No. _____

GETTING TO KNOW YOU

Why did you select our office? _____

Whom may we thank for referring you? _____

Is another member of your family or relative a patient in our practice? _____

CONSENT FOR TREATMENT

I authorize Dr. Fuqua to perform procedures, including but not limited to: giving anesthetics and medications, taking radiographs and photographs, restoring and extracting teeth and other procedures necessary for my therapy. X-rays, photographs and other records will remain the property of Dr. Fuqua and may be used for publication and teaching purposes. I hereby understand that I am financially responsible for services provided which is customarily paid on the day the services are rendered, unless prior arrangements have been made.

_____ _____ _____
SIGNATURE OF RESPONSIBLE PARTY RELATIONSHIP DATE

Patient Registration

Today's Date_____

Patient's Name _____ Birthdate _____
Last First Middle

DENTAL HISTORY

Reason For Today's Visit _____

Dentist Name_____

Dentist Address _____ Dentist Phone #_____

Date of last dental care _____ Date of last dental X-rays _____

Have you ever had any teeth removed? _____ How long have teeth been missing? _____

Have these teeth been replaced? _____ How? ❑ Bridge ❑ Partial ❑ Denture ❑ Implant

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations _____ If yes, describe _____

Have you ever had a blood transfusion ❑ Yes ❑ No If yes, give approximate dates _____

(Women) Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

Check if you have or have had any of the following:

❑ AIDS
❑ Anemia
❑ Angina Pectoris
❑ Arthritis
❑ Artificial Heart Valves
❑ Artificial Joints
❑ Asthma
❑ Back Problems
❑ Blood Disease
❑ Bruise Easily
❑ Cancer
❑ Chemotherapy
❑ Circulatory Problems
❑ Cold Sores
❑ Cortisone Treatments
❑ Diabetes
❑ Drug Addiction
❑ Epilepsy
❑ Fainting
❑ Frequent Chest Pains
❑ GI Problems
❑ Glaucoma
❑ Hay Fever
❑ Headaches
❑ Heart Murmur
❑ Heart Problems
Describe_____
❑ Hemophillia
❑ Hepatitis
❑ High Blood Pressure
❑ HIV Positive
❑ Implant Prosthesis
❑ Jaw Pain
❑ Kidney Disease
❑ Liver Disease
❑ Mitral Valve Problems
❑ Nervous Problems
❑ Pacemaker
❑ Psychiatric Care
❑ Radiation Treatment
❑ Respiratory Disease
❑ Rheumatic Fever
❑ Scarlet Fever
❑ Shortness of Breath
❑ Sickle Cell Trait
❑ Stroke
❑ Swelling of Feet or Ankles
❑ Thyroid Problems
❑ Tuberculosis
❑ Ulcer
❑ Venereal Disease

Are you presently, or have you ever been under the care of a physician during the past year?	❑ Yes ❑ No
Have you ever had a reaction to local anesthetic?	❑ Yes ❑ No
Have you ever experienced any complication or illness following dental treatment?	❑ Yes ❑ No
Do you have any diseases or conditions not listed above?	❑ Yes ❑ No
Do you use tobacco? (If yes, please circle and give frequency) Smoke: Cigarettes Cigars Pipe Frequency:_____ Smokeless: Chewing Tobacco Snuff or "Dip" Frequency:_____	❑ Yes ❑ No

MEDICATIONS

List medications you are currently taking:

_____
_____
_____
_____
_____
_____
_____

ALLERGIES

❑ Aspirin
❑ Penicillin
❑ Codeine
❑ Sulfa
❑ Latex
❑ Other
❑ Local Anesthetic

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date:_____

Dentist Comments:

Health History