

PATIENT INFORMATION:

Date: _____

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

Nickname (Preferred to be called): _____ DOB _____

Marital Status: Married Widowed Divorced Single Minor Male Female

Address: _____

City, State, Zip: _____

Telephone:(Home) _____ (Cell) _____

(Work) _____ (Pager) _____

E-Mail Address: (H) _____ (W) _____

Employer: _____ Position: _____ How Long: _____

School: _____ Grade: _____ S. S. # _____ - _____ - _____

Insured Name _____ SS#: _____ (DOB) _____

Group (Employer) Name: _____

Dental Insurance Company: _____ Telephone Number: _____

Has any member of your family been treated in our office before: Yes _____ No _____

If so whom: _____

Whom may we thank for referring you to our Office? _____

FAMILY INFORMATION:

Parents if a Minor / Spouse if Married

Father (or Husband)**Mother (or Wife)**

Name:

LAST FIRST M

LAST FIRST M

Address:

STREET CITY ZIP

STREET CITY ZIP

Telephone:

Home Work

Home Work

Birthday/SSN:

Mo. Day, Year SS#

Mo. Day, Year SS#

Employer:

How Long? _____

How Long? _____

Address

PERSON TO CONTACT OUTSIDE OF IMMEDIATE FAMILY IN CASE OF EMERGENCY

NAME: _____ Telephone: _____

Address: _____

City, State, Zip: _____

AUTHORIZATION:

Payment is due at the time of treatment. We accept MasterCard, Visa, American Express, Discover, personal checks, and cash. Assignments of Dental benefits are based on your policy provisions and honored whenever possible. In the event that your dental claim is not paid within a timely manner (within 75 days of submission), full payment of your balance is due and payable upon receipt of statement. In the case of minors, the parent/legal guardian scheduling the appointment is responsible for all cost incurred by the minor. Arrangements can be made with Dental Fee Plan or other companies to provide extended payments options, often with No or Low interest.

New treatment will not be initiated on patients if an account is past due. If your account becomes past due, we will take all necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all collection fees that are incurred. If we have to refer collection of your account to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs. In case of suit, you agree the venue shall be in San Antonio, Texas, Bexar County.

I have read the above information, and acknowledge the terms and commitments described.

Patient Signature

Driver's License # _____ State: _____

Parent or Responsible Party: _____ Relationship to Patient: _____

Reviewed by: _____ Date: _____

PATIENT NAME _____ DATE _____

MEDICAL HISTORY:

PLEASE CIRCLE

Medical doctor's name: _____
Are you under doctor's care now ? Why ? _____ YES NO
Date of last medical exam or medical doctors visit ? _____
Why ? _____
Have you been hospitalized during the last two years ? Why ? _____ YES NO
Are you taking any medication or substance ? _____ YES NO

Are you allergic to any medications or substance ? _____ YES NO
What ? _____

Indicate which of the following you had or have at the present. Circle :yes" or "no" to each item.

Heart Trouble	YES NO	Anemia	YES NO	Glaucoma	YES NO
High Blood Pressure	YES NO	Blood Transfusions	YES NO	Arthritis/Gout	YES NO
Low Blood Pressure	YES NO	Hemophilia	YES NO	Rheumatism	YES NO
Fainting or Dizziness	YES NO	Sickle Cell Anemia	YES NO	Ulcers	YES NO
Heart Murmur	YES NO	AIDS	YES NO	Psychiatric Care	YES NO
Rheumatic Fever	YES NO	Cancer	YES NO	Nervousness	YES NO
Congenital Heart Defects	YES NO	X-ray or Cobalt Treatmer	YES NO	Drug Addiction	YES NO
Artificial Heart Valves	YES NO	Chemotherapy /Radiation	YES NO	Venereal Disease	YES NO
Heart Pacemaker	YES NO	Stroke	YES NO	Herpes	YES NO
Heart Surgery	YES NO	Epilepsy or Seizures	YES NO	Fever Blisters	YES NO
Chest Pain	YES NO	Swollen Feet/Ankles/Han	YES NO	Cold Sores	YES NO
Artificial Joints/Hips	YES NO	Liver Disease	YES NO	Thyroid Disease	YES NO
Hepatitis A (Infectious)	YES NO	Yellow Jaundice	YES NO	Parathyroid Disease	YES NO
Hepatitis B (Serum)	YES NO	Excessive Thirst	YES NO	Hypoglycemia	YES NO
Diabetes	YES NO	Kidney Problems	YES NO	Shortness of Breath	YES NO
Allergies	YES NO	Emphysema	YES NO	Lung Disease	YES NO
Asthma	YES NO	Hay Fever	YES NO	Frequent Cough	YES NO
Sinus Problems	YES NO	Bruise Easily	YES NO		
Blood Disease	YES NO	Cortisone Medicine	YES NO		

Are you Pregnant ? _____ YES NO
Do you have any disease, condition, or problem not listed ? _____ YES NO
Please describe in detail: _____
Do you wish to talk to the doctor privately about any problem ? _____ YES NO

I understand that I am to report any change in mine/my child's medical history.

Patient Signature / Parent or Guardian _____ Date _____

Reviewed by Doctor _____ Date _____ B.P. _____

PATIENT NAME _____ DATE _____

DENTAL HISTORY:

PLEASE CIRCLE

What is the main reason for you visit today ? _____

Do you have a specific dental problem ? _____ YES NO
Describe: _____

Would you describe your dental health as good ? _____ YES NO
Comments: _____

When was your last dental visit ? _____

What was done then ? _____

Did you have X-rays ? _____ YES NO
How many ? _____

When was your last cleaning ? _____

Have you ever been told that you have gum disease ? _____ YES NO

Have you ever had gum treatment ? _____ When ? _____ YES NO

Do your gums bleed ? _____ YES NO
When ? _____

Do you feel you have bad breath at times ? _____ When ? _____ YES NO

How often do you brush your teeth ? _____ When ? _____

Do you floss your teeth ? _____ How often ? _____

Have any family members ever been told they have/had periodontal disease/Pyorrhea ? _____ YES NO

Do you think you have any cavities ? _____ YES NO
Why ? _____

Do you feel nervous about having dental treatment ? _____ YES NO
Why ? _____

Have you ever had a bad experience in a dental office ? _____ YES NO
Describe: _____

How long would you like to keep your teeth ? _____

Do you ever have clicking, popping, or discomfort in your jaw joints ? _____ YES NO
Discuss: _____

Have you ever had orthodontic treatment ? _____ YES NO

Do you like the appearance of your teeth ? _____ YES NO

Do you like your smile ? _____ YES NO

Do you like the color of your teeth ? _____ YES NO

Would you like to whiten your teeth ? _____ YES NO

Do you have spaces between your teeth ? _____ YES NO

Would you like to have these spaces closed ? _____ YES NO

Do you have discolored or old fillings ? _____ YES NO

Name of previous dentist: _____

CONSENT:

After a thorough evaluation, your dental needs will be discussed with you prior to treatment.

The undersigned hereby authorizes doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's needs. I also authorize to perform any and all forms of treatment, administer medication or provided therapy, that may be indicated. I further authorize and consent that the doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk.

Patient Signature _____ Date _____

Reviewed by: _____ Date _____

Parent or Responsible Party _____

Relationship to Patient _____