DALLAS STREET DENTAL

Patient Information (CONFIDENTIAL)

☐ Male ☐ Female

Today's Date_____

Home Phone_____

Cell:_____

Email _____

Name_____ Birthdate_____ Soc. Sec #_____

Address_____ City_____ State_____ Zip_____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or Parent's Employer_____ Work Phone_____

Business Address_____ City_____ State_____ Zip_____

Spouse or Parent's Name_____ Employer_____ Work Phone_____

If Patient is a Student, Name of School / College_____ City_____ State_____

Whom May We Thank for Referring You?_____

Person to Contact in Case of Emergency_____ Phone_____

How do you prefer to be contacted? ☐ Text ☐ Email ☐ Cell ☐ Home ☐ Work Please List_____

Responsible Party

Name of Person Responsible for this Account_____ Relationship to Patient_____

Address_____ Home Phone_____

Driver's License #_____ Birthdate_____ Cell Phone_____

Employer_____ Work Phone_____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No Name of Bank_____

Insurance Information

Name of Insured_____ Relationship to Patient_____

Birthdate_____ Social Security #_____

Name of Employer_____ Work Phone_____

Address of Employer_____ City _____ State_____ Zip_____

Insurance Company_____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No

Dental History

Reason for Today's Visit?_____

_____

Former Dentist_____

City/State_____

Date of last dental visit_____

Date of last dental X-rays_____

Place a check to indicate if you have any of the following:

Bad Breath ☐

Bleeding Gums ☐

Blisters on lips or mouth ☐

Burning sensation on tongue ☐

Chew on one side of mouth ☐

Cigarette pipe or cigar smoking ☐

Clicking or popping jaw ☐

Fingernail biting ☐

Food collection between the teeth ☐

Foreign objects ☐

Grinding teeth ☐

Gums swollen or tender ☐

Jaw pain or tiredness ☐

Lip or cheek biting ☐

Loose teeth or broken filings ☐

Mouth breathing ☐

Mouth pain, bruising ☐

Orthodontic treatment ☐

Pain around ear ☐

Periodontal treatment ☐

Sensitivity to cold ☐

Sensitivity to heat ☐

Sensitivity to sweets ☐

Sensitivity when biting ☐

Sores or growths in your mouth ☐

How often do you floss?_____

How often do you brush?_____

- OVER -

Health History

Physician_____ Office Phone_____ Date of Last Exam_____

✓ CHECK BOXES IF YOU HAVE ANY OF THE FOLLOWING

AIDS or HIV Infection ☐	Hay Fever / Allergies ☐	Recent Weight Loss ☐
Anemia ☐	Heart Attack ☐	Respiratory Problems ☐
Angina ☐	Date of Attack_____	Rheumatic Fever ☐
Artificial Heart Valves ☐	Heart Disease ☐	Scarlet Fever ☐
Arthritis ☐	Heart Murmur ☐	Shortness of Breath ☐
Asthma ☐	Heart Trouble ☐	Sexually Transmitted Disease ☐
Back Problems ☐	Hepatitis ☐	Sinus Trouble ☐
Bleeding Abnormally ☐	What Type_____	Skin Rash ☐
Blood Disease ☐	Herpes ☐	Stomach Troubles / Ulcers ☐
Cancer ☐	High Blood Pressure ☐	Stroke ☐
Cardiac Pacemaker ☐	Jaundice ☐	Swollen Ankles ☐
Chemical Dependency ☐	Joint Replacement or Implant ☐	Swollen Neck Glands ☐
Chemotherapy ☐	Date of Placement_____	Thyroid Problem ☐
Chest Pains ☐	Kidney Diseases ☐	Tonsillitis ☐
Circulatory Problems ☐	Liver Disease ☐	Tumor or growth on head or neck ☐
Cortisone Treatments ☐	Leukemia ☐	Tuberculosis ☐
Diabetes ☐	Low Blood Pressure ☐	Ulcer ☐
Emphysema ☐	Mitral Valve Prolapse ☐	Venereal Disease ☐
Epilepsy / Convulsions ☐	Nervous Problems ☐	Other_____
Fainting / Seizures ☐	Psychiatric Care ☐	_____
Glaucoma ☐	Radiation Therapy ☐	_____

☐ Are you under medical treatment now? ☐ Have you ever been hospitalized for any surgical operation or serious illness?

☐ Do you use tobacco? What kind?_____

☐ Do you use alcohol? ☐ Do you use cocaine? ☐ Do you use other drugs?

Women:

Are you pregnant? ☐ Due Date_____ Are you nursing? ☐ Taking birth control pills? ☐

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Pharmacy Name_____

Phone _____

Allergies

☐ Aspirin ☐ Local Anesthetics

☐ Barbiturates (Sleeping Pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other_____

☐ Latex _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of my dependents.

X_____

Signauture of patient or parent if minor

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