

**PATIENT INFORMATION UPDATE**

Dr./Mr./Mrs./Ms./Miss/Other \_\_\_\_\_ Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_  
Today's Date: \_\_\_\_\_  
Residence Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Residence Phone #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cellular phone/pager #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
E-mail address: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ TX Drivers License #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Business Phone #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Business Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
If child, name of parents: \_\_\_\_\_ If student, name of school: \_\_\_\_\_  
Spouse's Name: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_ Phone #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Spouse's Business Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
  
First person to contact in case of emergency: \_\_\_\_\_ Phone #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Nearest relative/friend not living with you: \_\_\_\_\_ Phone #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**ACCOUNT INFORMATION**

Person responsible for payment: \_\_\_\_\_ Phone #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Are any of your family members patients? YES NO Please list: \_\_\_\_\_  
  
Will you need financial arrangements to help with the cost of your dental treatment? YES NO

**COSMETIC DENTISTRY**

Please check any of the following cosmetic alternatives you might be interested in:  
 Teeth straightening       Teeth whitening       Filling spaces  
 Replacing silver fillings with tooth colored fillings       Bonding       Improving the overall appearance of your smile  
 Porcelain veneers

**DENTAL HEALTH UPDATE (Confidential)**

Please check if you have experienced any of the following:

<input type="checkbox"/> Periodontal/gum disease (How long ago? __)	<input type="checkbox"/> Loose teeth	<input type="checkbox"/> Jaw clicking or popping
<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Food packing between teeth	<input type="checkbox"/> Stiff neck muscles
<input type="checkbox"/> Receding gums	<input type="checkbox"/> High or rough fillings	<input type="checkbox"/> Pain/soreness around eyes, ears, jaw area
<input type="checkbox"/> Swelling of the gum	<input type="checkbox"/> Bad breath or taste in mouth	<input type="checkbox"/> Tension headaches
<input type="checkbox"/> Pain or soreness in gums	<input type="checkbox"/> Sensitivity to : __hot __cold	<input type="checkbox"/> Difficulty in opening/closing mouth
<input type="checkbox"/> Growths or swellings in mouth (How long existed? __)	<input type="checkbox"/> __pressure __biting	<input type="checkbox"/> Difficulty in chewing/swallowing
<input type="checkbox"/> Spaces between teeth	<input type="checkbox"/> __chewing __tooth brushing	
<input type="checkbox"/> Drifting teeth	<input type="checkbox"/> __sweets	
	<input type="checkbox"/> Clenching/grinding teeth	

# MEDICAL HEALTH HISTORY (Confidential)

Name: \_\_\_\_\_

Name of Primary Physician: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Please check if you have or have ever had any of the following:

## CARDIOVASCULAR/BLOOD

- Heart Murmur
- Artificial Heart Valve
- Mitral Valve Prolapse
- Heart Attack/Disease
- Heart Failure
- Heart Surgery
- Heart Pacemaker
- Chest Pains/Discomfort
- Circulatory Problems
- Rheumatic Fever
- Swollen Ankles
- High Blood Pressure
- Low Blood Pressure
- Excessive Bleeding
- Bruise Easily
- Anemia
- Hemophilia
- Leukemia
- Sickle Cell Disease
- Blood Transfusion

## NERVOUS SYSTEM

- Stroke
- Epilepsy/Convulsions
- Fainting/Dizziness
- Headaches

- Numbness/Tingling
- Nervous Disorders
- Psychiatric Treatment

## RESPIRATORY

- Tuberculosis
- Emphysema
- Asthma
- Hay Fever/Allergies/Hives
- Persistent Cough
- Shortness of Breath
- Respiratory Disease

## ENDOCRINE/URINARY

- Diabetes
- Thyroid Disease
- Kidney/Bladder Trouble

## DIGESTIVE

- Hepatitis A (Infection)
- Hepatitis B (Serum)
- Jaundice
- Ulcers
- Liver Disease
- Typhoid Fever

## BONES/MUSCLES

- Fractured Bones
- Artificial Joints
- Back Problems

## EYES/EARS/NOSE/THROAT/SKIN

- Glaucoma
- Ringing in Ears
- Sinus Problems
- Frequent Nosebleeds
- Scarlet Fever
- Herpes/Fever Blisters
- Lupus
- Measles/Mumps/Chicken Pox

## OTHER

- AIDS/HIV Positive
- Cancer
- Chemotherapy/Radiation
- Venereal Disease
- Anorexia/Bulimia
- Recent Weight Loss
- Alcoholism
- Drug Addiction
- Surgical Implants
- Other: \_\_\_\_\_

If you have marked any of the above, please briefly describe: \_\_\_\_\_

Please list any past hospitalizations/surgeries (minor or major): \_\_\_\_\_

Please describe any current medical treatment, impending operations, or other information that may affect your dental treatment: \_\_\_\_\_

## MEDICATIONS

List medications you are currently taking: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

## ALLERGIES TO MEDICATIONS

- Penicillin
- Codeine
- Aspirin
- Sulfa
- Barbiturates
- Local Anesthesia
- Other: \_\_\_\_\_

Have you ever been premedicated for your dental appointments in the past? YES NO

Do you frequently drink alcohol? YES NO Do you smoke tobacco? YES NO Do you use smokeless tobacco? YES NO

The above information is accurate and complete to the best of my knowledge. If any change occurs in my dental and/or medical health, I will report it to this office as soon as possible. I understand that I am and/or my parent or guardian is financially responsible for all fees related to my dental treatment.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_