(Please circle)

Dr.
Mr.
Ms. _____ BIRTHDATE _____
Mrs. Last Name First Name M.I.
Miss

How do you wish to be addressed? _____

RES. ADDRESS _____
Number Street City Zip Code

HOME PHONE _____ NAME OF SPOUSE _____

CELL PHONE _____

EMPLOYER _____

BUS. ADDRESS _____
Number Street City Zip Code

BUS. PHONE _____ S.S.N. _____ E-MAIL _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____

METHOD OF PAYMENT PREFERRED-CREDIT CARD (Master Card, Visa, Discover)
-CASH OR CHECK -CARE CREDIT

I, the undersigned (patient or legally responsible party), authorize dental treatment to be rendered by the Dentist and his staff, and assume financial responsibility.

Signature_____ **Date** _____

Insurance Information **Policyholder Information**

1. Policyholder _____ Employer _____

2. Policyholder's Birthdate _____

3. Name of insurance company _____

Group # _____ ID# and/or S.S.N. _____
Coverage A (Basic)_____ B (Major) _____ C (Orthodontics) _____
Limits _____ Deductible _____
Cert.# _____ Div.# _____ Dependent # _____

Do you have 2nd insurance coverage? YES NO

MEDICAL HISTORY (Confidential)

Physician's name _____ Physician's phone _____

(please circle)

YES NO 1. Are you under a physician's care at present? If yes, why: _____

_____

YES NO 2. Have you ever suffered from any major illnesses? _____

_____

YES NO 3. Are you taking any medicines or drugs of any kind? If yes, please name these drugs:

_____

YES NO 4. Have you any allergies, including medications? If yes, to what: _____

5. Do you have, or have you had any of the following problems? **If yes, please circle the condition:**

YES NO a. Heart trouble, heart attack, or stroke

YES NO b. Rheumatic fever or heart murmur

YES NO c. Chest pain, high blood pressure

YES NO d. Diabetes or hyperthyroidism

YES NO e. Seizures, convulsions, or epilepsy

YES NO f. Infectious, venereal, or communicable disease. If yes, identify: _____

YES NO g. Yellow jaundice or liver disease

YES NO h. Do you have a history, past or present, of chemical dependency?

YES NO i. Have you ever had radiation therapy to the head or neck regions?

YES NO 6. Do you have any blood disorders, or do you bleed excessively?

YES NO 7. Have you any other medical conditions (e.g.; A.I.D.S., Hepatitis) that are important for the dentist to know about?

YES NO 8. Are you in a high-risk group for A.I.D.S.?

YES NO 9. Have you <u>ever</u> taken Zometa?

FEMALES:

YES NO 10. Are you pregnant? If yes, what is your due date? _____

SIGNATURE: _____ DATE: _____

DENTAL HISTORY

Previous
Dentist_____Specialty_____
Address_____Phone_____

Why did you leave that practice?_____
Date of last dental visit?_____
Date of last full mouth x-rays?_____
Date of last complete dental examination?_____
Are you presently in any dental pain?_____
What is your immediate dental concern?_____
Have you experienced any unfavorable reaction to dentistry?_____
What?_____
Have you lost any teeth?_____
From what cause?_____
Have you ever had orthodontic treatment?_____When?_____
Do you have growths or swellings in your mouth?_____
How long have they existed?_____
Do you have any difficulty in swallowing?_____
Do your gums bleed when brushing your teeth?_____
Do you avoid brushing any part of your mouth?_____
Why?_____
Have you ever been told you have gum disease?_____When?_____
What do you do daily to take care of your mouth?_____
Do you smoke?_____How much?_____
Is any part of your mouth sensitive to temperature or pressure?_____
_____
Do you have a burning sensation in your mouth?_____
Have you ever had a bad reaction to dental anesthetic?_____
Does food catch between your teeth?_____
Any pain around your eyes, ears, or other parts of your face?_____
_____
Are you aware of stiff neck muscles?_____
Do you ever awaken with an awareness of your teeth and jaws?_____
Are you aware of clenching your teeth during daytime?_____
How often?_____
Have you ever been told you grind your teeth during your sleep?_____
Are you aware of clicking or popping in the jaw?_____How often?_____
Do you have any trouble opening your mouth wide?_____
Do you have tension headaches?_____How often?_____
Do you have an unpleasant taste or odor in your mouth?_____
Are you satisfied with your teeth and their appearance?_____
If not, what would you like to change?_____
_____
Do you think you will keep your teeth the rest of your life?_____
Have any members of your family, including your parents, ever worn dentures?_____
Do you feel your mouth is healthy?_____
Do you have any questions you would like to ask?_____
_____

Acknowledgement Of Receipt
Of
Notice Of Privacy Practices

I, _____ have received a copy of
(Name Of Patient)

CLEBURNE DENTAL CARE **Notice of Privacy Practices.**
(Name Of Practice)

_____
(Signature Of Patient)

Staff Will Fill Out This Section If Patient's Signature Not Obtained

Our office made a good faith effort to obtain **Acknowledgement of Receipt** of our Notice of Privacy Practices, but it could not be obtained for the following reason:

_____ Patient refused to sign.

_____ Emergency situation kept us from obtaining the patient's signature.

_____ Language barriers kept us from obtaining the patient's signature.

_____ Other _____