NEW PATIENT FORMS

Date:_____________

PATIENT INFORMATION

NAME____ HOME#________________________
FIRST MI LAST

ADDRESS____APT___________ WORK# _______________________

CITY__________________________ STATE_______ ZIP_______________ BIRTHDATE _________________________

SEX M / F (CIRCLE ONE) MR. MRS. MS. (CIRCLE ONE) DL #____________________ SS# ________________________

E-MAIL ADDRESS____ CELL#___________________________

BEST TIME OF DAY TO NOTIFY YOU? (CIRCLE ONE) AM / PM

WHOM MAY WE THANK FOR REFERRING YOU? ___________________________________

EMERGENCY CONTACT:_______________________________________PHONE:_________________________________

DENTAL INSURANCE INFORMATION

EMPLOYER_________________________________ INSURANCE CARRIER _______________________________

ID#_____________________________________ GROUP# _________________________________

SUBSCRIBER NAME __________________________________SUBSCRIBER D.O.B _________________________________

INSURANCE TELEPHONE # ___________________________________

PATIENT CONSENT FOR ELECTRONIC COMMUNICATION

I grant permission to Houston Medical Center Dental to communicate with me electronically, via email, voicemail or text messaging prior to an appointment. I understand that a message may be left regarding my appointment date and time. I also understand that I can unsubscribe at any time. I further understand that standard text message rates apply.

SIGNATURE: _______________________________________

SIGNATURE ON FILE FOR INSURANCE FILING

I authorize release of information to all of my Insurance Companies.
I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies.
I authorize payment directly to my doctor.
I permit a copy of this authorization to be used in place of the original.
PLEASE SIGN BELOW THAT YOU HAVE READ AND UNDERSTAND THE "SIGNATURE ON FILE" REQUIREMENTS FOR FILING YOUR INSURANCE.

SIGNATURE: _______________________________________ **DATE** ________________________

MEDICAL HISTORY

PATIENT NAME ____ _______________________DATE___________________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Thank you for answering the following questions.

Are you under a physician's care now? ☐Yes ☐No If yes, please explain:____________________________

Have you ever been hospitalized or had a major operation? ☐Yes ☐No If yes, please explain:____________________________

Have you ever had a serious head or neck injury? ☐Yes ☐No If yes, please explain:____________________________

Are you taking any medications, pills, or drugs ☐Yes ☐No If yes, please list:________________________________
____

Do you take, or have you taken, Phen-Fen or Redux? ☐Yes ☐No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐Yes ☐No

Are you on a special diet? ☐ Yes ☐No

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐Yes ☐No

Women Only:

Pregnant/Trying to get pregnant?☐Yes☐No Taking oral contraceptives?☐Yes☐No Nursing?☐Yes ☐No

Are you allergic to any of the following?

☐Aspirin ☐Penicillin ☐Codeine ☐Local Anesthetics ☐Acrylic ☐Metal ☐Latex ☐Sulfa drugs

☐Other allergies If so, please explain:____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ☐Yes☐No
Alzheimer's Disease ☐Yes☐No
Anaphylaxis ☐Yes☐No
Angina ☐Yes☐No
Arthritis/Gout ☐Yes☐No
Artificial Heart Valve ☐Yes☐No
Artificial Joint ☐Yes☐No
Asthma ☐Yes☐No
Blood Disease ☐Yes☐No
Breathing Problem ☐Yes☐No
Blood Transfusion ☐Yes☐No
Bruise Easily ☐Yes☐No
Cancer ☐Yes☐No
Chemotherapy ☐Yes☐No
Chest Pains ☐Yes☐No
Cold Sores/Fever Blisters ☐Yes☐No
Congenital Heart Disorder ☐Yes☐No
Convulsions ☐Yes☐No
Cortisone Medicine ☐Yes☐No

Diabetes ☐Yes☐No
Drug Addiction ☐Yes☐No
Easily Winded ☐Yes☐No
Emphysema ☐Yes☐No
Epilepsy or Seizures ☐Yes☐No
Excessive Bleeding ☐Yes☐No
Excessive Thirst ☐Yes☐No
Fainting Spells ☐Yes☐No
Dizziness ☐Yes☐No
Frequent Headaches ☐Yes☐No
Frequent Cough ☐Yes☐No
Frequent Diarrhea ☐Yes☐No
Genital Herpes ☐Yes☐No
Glaucoma ☐Yes☐No
Hay Fever ☐Yes☐No
Heart Attack ☐Yes☐No
Heart Murmur ☐Yes☐No
Heart Pacemaker ☐Yes☐No
Heart Disease ☐Yes☐No

Heart Trouble ☐Yes☐No
Hemophilia ☐Yes☐No
Hepatitis A ☐Yes☐No
Hepatitis B or C ☐Yes☐No
Herpes ☐Yes☐No
High Blood Pressure ☐Yes☐No
High Cholesterol ☐Yes☐No
Hives or Rash ☐Yes☐No
Hypoglycemia ☐Yes☐No
Irregular Heartbeat ☐Yes☐No
Kidney Problems ☐Yes☐No
Leukemia ☐Yes☐No
Liver Disease ☐Yes☐No
Low Blood Pressure ☐Yes☐No
Lung Disease ☐Yes☐No
Mitral Valve Prolapse ☐Yes☐No
Osteoporosis ☐Yes☐No
Pain in Jaw Joints ☐Yes☐No

Parathyroid Disease ☐Yes☐No
Psychiatric Care ☐Yes☐No
Radiation Treatment ☐Yes☐No
Recent Weight Loss ☐Yes☐No
Renal Dialysis ☐Yes☐No
Rheumatic Fever ☐Yes☐No
Rheumatism ☐Yes☐No
Scarlet Fever ☐Yes☐No
Shingles ☐Yes☐No
Sickle Cell Disease ☐Yes☐No
Sinus Trouble ☐Yes☐No
Spina Bifida ☐Yes☐No
Stomach/Intestional Diease ☐Yes☐No
Swelling of Limbs ☐Yes☐No
Stroke ☐Yes☐No
Thyroid Disease ☐Yes☐No

SMILE EVALUATION

1. If you could change anything about your smile, what would you change?
____
____

2. Would you like your teeth to be whiter? Yes ( ) No ( )

3. Would you be interested in braces/invisalign? Yes ( ) No ( )

4. Do you have missing teeth that you would like to replace? Yes ( ) No ( )

5. Do you have old silver fillings that you would like to be replaced with tooth-colored fillings? Yes ( ) No ( )

6. Do you have any fears or anxiety about dental work? Yes ( ) No ( )

Explain: ____
____

ACKOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (PLEASE PRINT) ________________________________, have read &/or received a copy of this office's Notice of Privacy Practices.

____ ________________________

SIGNATURE DATE