PATIENT INFORMATION

PERSONAL INFORMATION

Last Name: ____________________________ First Name: _______________________ M.I.: _____ Nickname: ________________

Address: ____

City: ____ State: ___________ Zip Code: ______________________

Home: (_______) _____________________ Work: (_______) _____________________ Cell: (_______) _____________________

Email: ____ Preferred Contact Method: ____________________

SSN: ________________________________ Driver License (State/#): _______________________________ Sex: **M** **F**

Age: _______ DOB: ______________________ Marital Status: ____________ Spouse's Name: ___________________________

Employer: ____ Occupation: _________________________________

Emergency Contact: ____

Name Phone Number Relation

Information of Responsible Party:

Last Name: ____________________________ First Name: _______________________ M.I.: _____ Nickname: ________________

Address: ____

City: ____ State: ___________ Zip Code: ______________________

Home: (_______) _____________________ Work: (_______) _____________________ Cell: (_______) _____________________

SSN: _________________________ Driver License (State/#): _____________________ Sex: **M** **F** DOB: ________________

Dental Insurance Information:

Do you have dental insurance that you would like help filing? **Yes** **No**

If yes, please provide us with your information and we will be happy to file it on your behalf.

How did you hear about The DFW Dental Implant Center? ____

DENTAL HISTORY

1. What is your primary reason for visiting our dental office? ____
2. Do you have dental examinations on a routine basis? **Yes** **No** Year of last exam? _________________________________
3. How many times per day do you brush your teeth? ___________ Floss? __________ Use Mouthwash? ____________________
4. Do your gums bleed when you brush? ________ When was your last teeth cleaning? ____________________________________
5. If you could change anything about your smile, what would it be? ____
6. Do you have missing teeth that you would like to replace? ____
7. Are your teeth sensitive to cold / hot water or air? ____
8. Do you have a history of grinding or clenching your teeth? ____
9. Do you have clicking or popping in your jaw? Pain? ____
10. Does your mouth feel dry? ____
11. Name of your previous dentist? (Optional) ____

MEDICAL HISTORY

1. Name of your current physician? ____ Date of Last Exam: ____________________
2. Have you ever been hospitalized or had a major operation? Discuss ____
3. Have you ever had a serious injury to your head or neck? Discuss ____
4. Have you ever undergone chemotherapy or radiation therapy to your head or neck? ____________________________________
5. Do you currently smoke cigarettes or chew tobacco? **Y** **N** Packs per day? ____________ # of Years? ______________
6. Have you ever smoked cigarettes or chewed tobacco in the past? **Y** **N** How long since you quit? ________________
7. Do you have diabetes? **Y** **N** Type? **I** **II** Controlled or Uncontrolled? **Y** **N** HbA1c Value? ___________
8. Have you ever taken Fosamax, Boniva, Actonel or any other oral or IV bisphosphonate medication? _________________________
9. Have you ever been or are you currently being treated for drug addiction or alcoholism? __________________________________

Please check ALL medical conditions that apply:

☐ AIDS / HIV Positive	☐ Chronic Bronchitis	☐ Heart Trouble / Disease	☐ Nervousness
☐ Alzheimer's Disease	☐ Cold Sores / Fever Blisters	☐ Hemophilia	☐ Psychiatric Care
☐ Anaphylactic Allergic Rxn	☐ Congenital Heart Disease**	☐ Hepatitis A, B or C	☐ Recent Weight Loss
☐ Anemia	☐ Cortisone Medicine	☐ Herpes	☐ Rheumatic Fever
☐ Angina (Chest Pain)	☐ Diabetes	☐ High Blood Pressure	☐ Sexually Transmitted Disease
☐ Artificial Heart Valve**	☐ Emphysema	☐ High Cholesterol	☐ Shortness of Breath
☐ Artificial Joint Replacement**	☐ Epilepsy or Seizures	☐ Hip or Knee Replacement**	☐ Sickle Cell Disease
☐ Asthma	☐ Excessive Bleeding	☐ Hx of Infective Endocarditis**	☐ Sinus Trouble
☐ Benign Tumors or Growths	☐ Excessive Thirst	☐ Irregular Heartbeat	☐ Stomach / Intestinal Disease
☐ Blood Disease	☐ Fainting Spells / Dizziness	☐ Kidney Disease/Dialysis	☐ Stroke
☐ Breathing Problems	☐ GERD / Gastric Reflux	☐ Leukemia	☐ Swelling of Limbs
☐ Bruise Easily	☐ Glaucoma	☐ Liver Disease	☐ Thyroid Disease
☐ Cancer	☐ Heart Attack / Failure	☐ Lung Disease	☐ Tuberculosis
☐ Cardiac Transplant**	☐ Heart Murmur	☐ Mitral Valve Prolapse	☐ Ulcers
☐ Chemo / Radiation Therapy	☐ Heart Pacemaker	☐ Osteoporosis	☐ Yellow Jaundice

Please list all medications, vitamins, herbals, pills or drugs that you are currently taking? ______________________________

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Are you allergic to any of the following?

☐ Penicillin/Amoxicillin	☐ Local Anesthetics (Novocaine)	☐ Iodine
☐ Sedative Medications	☐ Sulfa Drugs	☐ Latex
☐ Aspirin	☐ Hydrocodone/Codeine	☐ Other ____________

To the best of my knowledge, all of the preceding answers are correct, and I have listed all of my past and present health conditions, along with any medications that I am currently taking. If I have any changes in my health status or if my medications change, I shall inform the dentist and staff at the next appointment without fail.

Signature: ____ Date: ____________________

Patient Signature (Parent or Guardian)

Signature: ____