Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us

2615 WEST 24TH STREET • PLAINVIEW, TX 79072 • (806) 296-6057

PATIENT INFORMATION

Name _____ Birthdate _____SS# _____

Sex: □ Male □ Female Home/ Cell _____ Text? □YES □NO

Referral Source - How did you hear about us? _____

PARENT/ LEGAL GUARDIAN 1

Lives with Child□ YES □ NO

Name _____ Relation to Pt _____

Birthdate _____ SS# _____Home/ Cell _____

Address _____ City _____ State _____ Zip _____

□ Married□ Single□ Other _____Email _____

PARENT/LEGAL GUARDIAN 2

Lives with Child□ YES □ NO

Name _____ Relation to Pt _____

Birthdate _____ SS# _____Home/ Cell _____

Address _____ City _____ State _____ Zip _____

□ Married □ Single □ Other _____Email _____

INSURANCE INFORMATION – PRIMARY

Must provide a copy of the insurance card

Insurance Name _____ Insurance Phone _____

Insurance ID #_____ Insurance Group # _____

Name of Subscriber _____ Relation to Patient _____

Date of Birth _____ SS# _____ Home/ Cell _____

Address _____ City _____ State _____ Zip _____

Employer Name _____ Employer Phone # _____

INSURANCE INFORMATION – SECONDARY

Must provide a copy of the insurance card

Name of Insured _____ Relation to Pt _____

Insurance Name _____ Insurance Phone _____

Insurance ID #_____ Insurance Group # _____

Name of Subscriber _____ Relation to Patient _____

Date of Birth _____ SS# _____ Home/ Cell _____

Address _____ City _____ State _____ Zip _____

Employer Name _____ Employer Phone # _____

DENTAL HISTORY

Patient Name:

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental x-rays _____

Contact Information _____

Check if you have or have had problems with any of the following:

- □ Bad Breath
- □ Bleeding Gums
- □ Clicking or popping jaw
- □ Food collection between teeth
- □ Grinding Teeth
- □ Loose teeth or broken fillings
- □ Periodontal treatment
- □ Sensitivity to cold
- □ Sensitivity to hot
- □ Sensitivity to sweets
- □ Sensitivity when biting
- □ Sores or growths in the mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Contact Information _____

Have you ever had any serious illnesses or operations? □ No □ Yes: _____

Have you ever had a blood transfusion? □ No □ Yes: _____

(Female) Are you pregnant? □ No □ Yes – Due Date: _____ Taking Birth Control Pills? □ No □ Yes

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of lonimin, Adipex, Fastin (brand names of phentermine), Pndimin (fenfluramine) and Redux (dexfenfluramine). □ No □ Yes

Check if you have or have had problems with any of the following:

- □ Anemia
- □ Arthritis, Rheumatism
- □ Artificial Heart Valves
- □ Artificial Joints, Pins, Etc.
- □ Asthma
- □ Back problems
- □ Bleeding abnormally
- □ Blood disease
- □ Cancer
- □ Chemical Dependency
- □ Chemotherapy
- □ Circulatory Problems
- □ Congenital Heart lesions
- □ Cortisone Treatments
- □ Cough, Persistent
- □ Cough up Blood
- □ Diabetes
- □ Epilepsy
- □ Fainting
- □ Glaucoma
- □ Headaches
- □ Heart Murmur
- □ Heart Problems
- □ Hemophilla
- □ Hepatitis
- □ Hernia Repair
- □ High Blood Pressure
- □ HIV/AIDS
- □ Jaw Pain
- □ Kidney Disease
- □ Liver Disease
- □ Mitral Valve Prolapse
- □ Pacemaker
- □ Radiation Treatment
- □ Respiratory Disease
- □ Rheumatic fever
- □ Scarlet Fever
- □ Shortness of Breath
- □ Skin Rash
- □ Stroke
- □ Swelling of Feet or Ankles
- □ Thyroid Problems
- □ Tobacco Habit
- □ Tonsillitis
- □ Tuberculosis
- □ Ulcer
- □ Venereal Disease

Does your child have any syndromes or medical conditions? _____

List medications you are currently taking: _____

_____

_____

Allergies:

- □ ASPIRIN
- □ Barbiturates (Sleeping Pills)
- □ CODEINE
- □ Local Anesthetic
- □ PENICILLIN
- □ SULFA
- □ Iodine
- □ LATEX
- □ None
- □ Other _____ _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child ever have a change in health.

_____

PRINT NAME of Parent, Guardian or Personal Representative

_____ _____

Signature of Parent, Guardian or Personal Representative Date