



DFW FAMILY DENTISTRY

PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Patient Name _____
Birthdate _____ Last _____ First _____ MI _____ (Preferred)
SS# _____ DL# _____ Gender: M F Married: Y N
Work Phone _____ Wireless Phone _____ Email _____

If patient is under 18 yrs, please also complete the following:

Guarantor Name _____
Birthdate _____ Last _____ First _____ MI _____ (Preferred)
SS# _____ DL# _____ Gender: M F Married: Y N
Work Phone _____ Wireless Phone _____ Email _____

Preferred contact method Hm Phone Wk Phone Wireless Ph Email

Student status if dependent over 19 (for ins) Nonstudent Fulltime Part time

How did you hear about us? (Please be specific so we can thank them!) _____

ADDRESS AND HOME PHONE

Check box if same for entire family

Address _____

Address 2 _____

City _____ State _____ Zip _____

Home Phone _____

INSURANCE POLICY 1

Patient relationship to subscriber: Self Spouse Child

Sub. Name _____ Sub.ID # _____ Sub.DOB _____

Insurance Company _____ Phone _____

Employer _____ Group Name _____ Group # _____

INSURANCE POLICY 2

Patient relationship to subscriber: Self Spouse Child

Sub. Name _____ Sub.ID # _____ Sub.DOB _____

Insurance Company _____ Phone _____

Employer _____ Group Name _____ Group # _____

Comments: _____

Please complete reverse side.

FINANCIAL AGREEMENT

For my convenience, this office may release information to my insurance and receive payments directly from them.
If sent to collections, I agree to pay a \$30 collection fee and all related fees and court costs.
Every effort will be made to collect payment from my insurance. But if they do not pay as expected, I am responsible.
Treatment plans and clinical circumstances may change. I will be financially responsible for the actual treatment completed.
I acknowledge that I will be charged a \$25 cancellation fee if cancelling an appointment with less than 24hrs notice.

MEDICAL HISTORY

Name of Medical Doctor: _____ Doctor City / State: _____
Emergency Contact: _____ Emergency Phone Number: _____

List Medications You Are Now Taking:

Check Which Of The Following You Are Allergic To:

<input type="checkbox"/> None	<input type="checkbox"/> Metals
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Anesthetics
<input type="checkbox"/> Codein / Narcotics	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Sulfa Drugs

Other: _____

Check Any Medical Conditions You Have Had:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Heart Attack / Stroke | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> AIDS / HIV | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Heart Disease / Angina | <input type="checkbox"/> Persistent Diarrhea |
| <input type="checkbox"/> Alcohol / Drug Abuse | <input type="checkbox"/> Damaged Heart Valve | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia / Leukemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis / Jaundice | <input type="checkbox"/> Rheumatic Heart Disease |
| <input type="checkbox"/> Anorexia / Bulimia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hives / Skin Rash | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Asthma / Hay Fever | <input type="checkbox"/> Fainting / Seizures | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Blood Clot Problems | <input type="checkbox"/> Fever Blister / Herpes | <input type="checkbox"/> Kidney / Bladder Trouble | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Brinchnitis | <input type="checkbox"/> Dry Mouth / Sjogren | <input type="checkbox"/> Low Blood Pressure | |
| <input type="checkbox"/> Cancer / Tumor | <input type="checkbox"/> Gall Bladder Trouble | <input type="checkbox"/> Mental Health Problems | |

Other: _____

Do you use tobacco? If so, what kind and how much? _____

Do you have any unusual reactions to dental injections? _____

Are you pregnant or have any reason to believe you may be? Yes No

Do you take vitamin supplements? Yes No Do you take weight loss supplements? Yes No
Do you purchase primarily organic foods? Yes No Do you take work out supplements? Yes No
Do you take mealth replacement shakes? Yes No Do you drink energy drinks? Yes No

Do you wish your smile was prettier? Yes No Do you have any missing teeth? Yes No
Do you have crooked teeth? Yes No Do you have any dental pain? Yes No

Reason for today's visit:

By signing below I certify that all of the above information is true to the best of my knowledge.

Name of Patient / Guardian (printed)

Signature

Date