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_____
Last First MI (Preferred)

Birthdate_____ 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*_____
Last First MI (Preferred)

*Birthdate*_____ *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 conveniece, 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:

- ☐ None
- ☐ Aspirin
- ☐ Codein / Narcotics
- ☐ Aspirin
- ☐ Metals
- ☐ Anesthetics
- ☐ Penicillin
- ☐ Sulfa Drugs

Other: _____

Check Any Medical Conditions You Have Had:

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

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 _____