precise
DENTAL OF HOUSTON

Patient Information

*Patient Name:*_____
Last *First* *Middle*

*Address:*_____*City/State:*_____*Zip:*_____

*Home Phone:*_____ *Work Phone:* _____ *Cell Phone:* _____

Email: _____

I prefer to be contacted by: ( )Home ( )Work ( )Cell ( )Email

*Date of Birth:*_____ *Age:*_____ *Social Security #:*_____ *Gender: M / F*

*Occupation:*_____ *Employer:*_____

*Business Address:*_____ *Business Phone:*_____

*Who may we thank for referring you?*_____

Emergency Contact

*Notify in case of emergency:*_____ *Relationship to Patient:*_____

*Phone (1):*_____*Phone (2):*_____

Patient Account Information

Will you be using an existing Dental Policy for your visit? Y or N

Person Responsible for Account: _____
Last *First* *Middle*
*Home Phone:*_____ *Work Phone:* _____ *Cell Phone:* _____

*Relationship to Patient:*_____ *Address:*_____

*DOB of Responsible person:*_____ *Employer:*_____

*Insurance Company:*_____ *Insurance Phone #:*_____

*Member #:*_____ *Group #:*_____

Dental History

*What are your primary concerns?*_____

*Are you experiencing any discomfort currently?*_____ *Date of last Oral Care:*_____

*Date of last dental X-rays:*_____ *Reason for visit:*_____

Have you ever or currently have any of the following issues:
Check all that apply.

( )Bad Breath ( )Bleeding Gums ( )Food collection between teeth ( )Clicking or Popping of Jaw

( )Grinding or Clenching ( )Loose teeth or broken fillings ( )Sensitivity to temperature ( )Jaw Pain

( )Sensitivity to biting or chewing ( )Sores or Growths in the Mouth

*( )Tobacco Use, if yes, What type:*_____ *How often:*_____

Do you like the physical appearance of your teeth? Y or N

Do you like the color of your teeth? Y or N

*Explain:*_____

Do you have anxiety regarding dental treatment? Y or N

Do you normally require Nitrous Oxide (laughing gas)? Y or N

Are you interested in Sedation Dentistry? Y or N

*What would you like to achieve during your dental visit?*_____

_____.

*Is there anything else we should know about you?*_____

_____.

Medical History

*Physician Name:*_____ *Phone:*_____

*Date of last visit with Physician:*_____

Have you ever had any serious illness or operations? Y or N

Are you currently under the care of a physician? Y or N

Have you ever had a blood transfusion? Y or N *Dates:*_____

Have you ever taken Fen-Phen/Redux? Y or N

Women: Are you pregnant? Y or N *Nursing? Y or N* *Taking Birth Control? Y or N*

Have you ever had any of the following: Please check for Yes and leave blank for No.

( )Aids/HIV	( ) Chemotherapy	( ) Headaches	( ) Rheumatic/Scarlet Fever
( ) Anaphylaxis	( ) Circulatory Problems	( ) Heart Murmur	( ) Shingles
( ) Anemia	( ) Cortisone Treatments	( ) Heart problems	( ) Shortness of Breath
( ) Arthritis, Rheumatism	( ) Persistent Cough	( ) Hemophilia/Abnormal Bleeding	
( ) Artificial Heart Valves	( ) Cough up Blood	( ) Herpes	( ) Stroke
( ) Artificial Joints	( ) Diabetes	( ) Hepatitis	( ) Surgical Implant
( ) Asthma	( ) Epilepsy	( ) High blood pressure	( ) Swelling of feet/ankles
( ) Atopic/allergy prone	( ) Fainting	( ) Kidney Disease	( ) Thyroid Disease
( ) Back Problems	( ) Food Allergies	( ) Liver Disease	( ) Tuberculosis
( ) Blood Disease	( ) Glaucoma	( ) Mitral Valve Prolapse	( ) Ulcer/Colitis
( ) Cancer-What Type:_____		( ) Pacemaker/Heart Surgery	( ) Venereal Disease
( ) Chemical Dependency	( ) Psychiatric Care	( ) Radiation Treatment	

Medications currently being taken:_____

Are you aware of any drug allergies? If yes, list all:_____

I have reviewed the information provided above, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthy dental treatment. If there are any changes in my medial status, I will notify the dentist.

Patient Signature:_____ Date:_____