



3951 W Parmer Lane, Suite 200, Austin, TX 78727
(512) 491-5244



Date _____

Name _____ Previous Dentist's Name _____
First Last MI
Address _____ City _____ State _____ Zip Code _____
Social Security # _____ - _____ - _____ Date of Birth _____ Date of last exam _____
Cell _____ Home/Work Ph _____ Email _____

If you are completing this form for another person, what is your relationship to that person? _____

INSURANCE INFORMATION

Policy Holder _____ Date of Birth _____ Employer _____
Insurance Carrier _____ Social Security # or Subscriber ID# _____

PATIENT MEDICAL HISTORY

For the following questions, circle yes or no. Your answers are for our records only and will be considered confidential. Please note that during your initial visit, you will be asked some questions about your responses to this questionnaire, and there may be additional questions about your responses and those concerning your health.

- 1. Are you in good health? Yes No
2. Has there been any changes in your general health within the past year? Yes No
3. My last physical exam was on _____
4. Are you currently under a physician's care? Yes No
5. The name and phone number of my physician is:
Name _____
Ph _____
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? Yes No
7. Are you taking any medication(s), including non-prescription medicine(s)? Yes No
If so, which ones? _____
8. Do you have any of the following medical conditions?
a. Damage to heart valves, heart murmur, or rheumatic heart disease. Yes No
b. Cardiovascular disease, angina, heart attack, stroke. Yes No
c. Osteoporosis. Yes No
d. Require(d) chemotherapy. Yes No
e. Asthma or Hay Fever. Yes No
f. Fainting spells or seizures. Yes No
g. Diabetes. Yes No
h. Hepatitis, jaundice, liver disease. Yes No
i. AIDS or HIV infection. Yes No
j. High/Low blood pressure. Yes No
k. Has had abnormal bleeding or a bleeding disorder. Yes No
l. Has had an allergic reaction to:
a. Local anesthetics. Yes No
b. Penicillin/antibiotics. Yes No
c. Sulfa drugs. Yes No
d. Barbiturate or sedatives. Yes No
e. Codeine or narcotics. Yes No
f. Other _____
m. Recent weight loss. Yes No
n. Cancer. Yes No

Women Only:

- 9. Are you pregnant or nursing? Yes No
10. Are you taking oral contraceptives? Yes No

PATIENT DENTAL HISTORY

- 1. Do your gums bleed while brushing or flossing? Yes No
2. Are your teeth sensitive to hot/cold? Yes No
3. Are your teeth sensitive to sweet/sour? Yes No
4. Do you have sores or lumps near your mouth? Yes No
5. Have you had head, neck, or jaw injuries? Yes No
6. Have you had any of the following concerning your jaw:
a. Clicking. Yes No
b. Pain (joint, ear, side of face). Yes No
c. Difficulty opening/closing/chewing. Yes No
7. Do you clench or grind your teeth? Yes No
8. Do you bite your cheek/lip frequently? Yes No
9. Have you had orthodontic treatment? Yes No
10. Do you wear dentures/partials? Yes No
12. Have you had difficulty with an extraction in the past? Yes No

Authorization and Release

I certify that I have read and understand the above information. The above questions have been answered accurately. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form. I authorize the dentist to release information including the diagnosis and records to third party payors and/or health practitioners. I have read and understand the HIPPA document. I understand that my dental insurance may pay less than the actual bill for services and I will then be responsible for the difference in fees.

X _____
(Signature of patient (or parent/guardian if minor))