HOUSTON DENTAL PARTNERS
Advanced Dentistry

Welcome

We would like to get to know you better!

We warmly welcome you to our office. Please take a few moments to complete the following information so that we can better care for you. It is our goal to help you reach and maintain maximum oral health.

PATIENT INFORMATION

Name: _____

I prefer to be called:_____ Male Female

Birth date: _____ SSN:_____

Home address:_____

_____

Hm # _____ Cell #_____

Wk # _____

Email _____

How do you prefer to confirm your appointments?

_____

Employer: _____

_____

Occupation: _____

Whom may we thank for referring you? _____

Other family members seen by us?

_____

Previous / present Dentist: _____

Date of last visit : _____ Ph# _____

Dental Insurance

Primary Dental Insurance

Insurance co. name: _____

Phone: _____

Group # or Policy # _____

Insured's name: _____

Insured's employer: _____

Relation: _____

Insured's birth date: _____

Insured's SSN or ID # _____

Secondary Dental Insurance

Insurance Co. Name: _____

Phone #_____

Group or Policy # _____

Insured's Name: _____

Relation: _____

Insured's birth date: _____

Insured's SSN or ID #_____

In the event of an emergency, whom should we contact?

Name:_____

Relation:_____

Cell# _____Email _____

FINANCIAL INFORMATION:

A note for patients with dental insurance – We will assist you to maximize your insurance benefits, and we are happy to file claims to your insurance carrier and agree to accept payment from any carrier that offers an assignment of benefits, if you desire. We will do our best to calculate your available benefit amount, however, regardless of what your insurance plan pays, you are responsible for all fees.

Medical History

Are you currently under the care of a physician? ☐ **Yes** ☐ **No** If **yes**, please explain:

_____

Please list ALL medications and supplements:

_____

_____

_____

Do you use or smoke tobacco in any form? ☐ Yes ☐ No

Have you or do you take Redux/Fen Phen or Pondimin? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Trimester? _____ Nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Y	N	Alzheimer's disease	Y	N	Hemophilia
Y	N	Alcohol/Drug Abuse	Y	N	Hepatitis A, B or C
Y	N	Anemia	Y	N	High Blood Pressure
Y	N	Arthritis	Y	N	HIV+AIDS
Y	N	Artificial Bones/Joints	Y	N	Kidney Problems
Y	N	Asthma	Y	N	Liver Disease
Y	N	Blood Transfusions	Y	N	Low Blood Pressure
Y	N	Cancer/Chemotherapy	Y	N	Mitral Valve Prolapse
Y	N	Colitis	Y	N	Osteoporosis
Y	N	Congenital Heart Defect	Y	N	Psychiatric Care
Y	N	Diabetes	Y	N	Radiaton
Y	N	Difficulty Breathing	Y	N	Rheumatic/Scarlett Fever
Y	N	Emphysema	Y	N	Seizures
Y	N	Epilepsy	Y	N	Shingles
Y	N	Fainting Spells	Y	N	Sickle Cell Disease
Y	N	Fever Blisters/Cold Sores	Y	N	Sinus Problems
Y	N	Frequent Headaches	Y	N	Stomach/Intestinal Issues
Y	N	Glaucoma	Y	N	Stroke
Y	N	Hay Fever	Y	N	Thyroid Problems
Y	N	Heart Attack	Y	N	Tuberculosis
Y	N	Heart Murmur	Y	N	Ulcers
Y	N	Heart Pacemaker	Y	N	Venereal Disease

Please list any serious medical condition (s), surgeries, or reason for being hospitalized that you have ever had:

_____

_____

_____

Are you allergic to any of the following items?

Y	N	Aspirin	Y	N	Latex
Y	N	Codeine	Y	N	Penicillin
Y	N	Dental Anesthetics	Y	N	Tetracycline
Y	N	Erythromycin	Y	N	Sulfa Drugs

Please list any other drugs you are allergic to:

_____

Dental History

Why have you come to the dentist today? _____

_____

Many patients consult us for a 2nd opinion. Are you currently seeing another dentist for your dental needs? ☐ Yes ☐ No

If Yes, please explain: _____

Do you have history of periodontal disease? ☐ Yes ☐ No

Are you currently in pain or discomfort with your teeth or gums? ☐ Yes ☐ No If yes, please explain:_____

How often do you brush your teeth? _____ Floss? _____

Do your gums bleed when you brush? ☐ Yes ☐ No

Do your gums bleed when you floss? ☐ Yes ☐ No

Have you ever experienced pain in you jaw joint? ☐ Yes ☐ No

Have you ever been treated for TMJ symptoms? ☐ Yes ☐ No

If yes, please explain: _____

Do you grind or clench your teeth? ☐ Yes ☐ No

HIPPA Compliance Statement: Your health information may be used in our office to conduct scheduling and coordination of care between the doctor, dental assistant, hygienist, business staff and other health care providers. We may include your health information (including x-rays) with communications related to your treatment and we may do this with insurance claim forms. We may communicate with you via phone, text messages, postcards/letters, or electronically.

MEDICAL HISTORY: I understand that this information is correct to the best of my knowledge. I understand it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

CONSENT: I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I give permission for the doctor or their staff to use any photos taken for lecturing, publishing, educational, or promotional purposes.

Signature: _____

Date: _____

Patient portion is due in full at the time of treatment

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