TEXAS DENTAL CENTER

WELCOME

PATIENT INFORMATION

Date: _____

SS #:_____Date of birth: _____

Sex:____M____F Age: _____

Patient Name:

_____

Last Name First Name Middle Initial

Preferred Name:_____

Mailing Address: _____

City:_____State:_____Zip: _____

E-mail: _____

Occupation: _____

Employer/ School: _____

_____Married ___Widowed ___Single____Minor

___Separated ___Divorced ___Partnered for_____years

How did you hear about our office?

_____

PHONE NUMBERS (To reach you regarding appointments)

Home: (_____) _____

Work: (_____) _____

Cell Phone: (_____) _____

Best time and place to reach you: _____

IN CASE OF EMERGENCY CONTACT

Name: _____

Relationship: _____

Home Phone/ Cell: (_____) _____

Work Phone: (_____) _____

DENTAL INSURANCE

PLEASE PROVIDE INSURANCE CARD TO RECEPTIONIST

Who is responsible for this account?

Name: _____

DOB: _____

ID/SS: _____

Employer: _____

Relationship to Patient: _____

Insurance Co. _____

ASSIGNMENT AND RELEASE

I authorize my insurance company to pay Drs. Al Manesh & Amir Mofid all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize Texas Dental Center to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand payment is due in full at the time of treatment. I understand that I will be charged for a broken appointment fee when less than 48 hours notice is given and this amount must be paid before any future care can be given. I acknowledge I have received the HIPAA Notice of Privacy Practices

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative **Date**

DENTAL HISTORY

Reason for today's visit: _____

Date of last dental visit:_____

Date of last full mouth X-rays: _____

How often do you floss?_____

How often do you brush? _____

Is there anything you want to change about your smile? _____

Name:_____ **Date of birth:** _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	___Yes ___No	Gums swollen or tender	___Yes ___No
Bleeding gums	___Yes ___No	Jaw pain or Headaches	___Yes ___No
Cigarette, pipe, or cigar smoking	___Yes ___No	Orthodontic treatment	___Yes ___No
Clicking or popping jaw	___Yes ___No	Pain around ear (ringing)	___Yes ___No
Dry Mouth	___Yes ___No	Sensitivity with teeth	___Yes ___No
Grinding teeth (Clench)	___Yes ___No	Snoring while you sleep?	___Yes ___No

HEALTH HISTORY

Physician's Name_____Telephone_____Date of last visit: _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	___Yes ___No	Bruise Easily	___Yes ___No
Artificial Heart Valves	___Yes ___No	Chemical Dependency	___Yes ___No
Pacemaker	___Yes ___No	Circulatory Problems	___Yes ___No
Heart Attack	___Yes ___No	Cortisone Treatments	___Yes ___No
Any metal pins in the body	___Yes ___No	Cough (persistent or bloody)	___Yes ___No
Any Implants (Breast)	___Yes ___No	Do you wear contact lenses?	___Yes ___No
High Blood Pressure	___Yes ___No	Epilepsy	___Yes ___No
Artificial Joints	___Yes ___No	Fainting or dizziness	___Yes ___No
Diabetes	___Yes ___No	Headaches	___Yes ___No
Radiation Treatment	___Yes ___No	Herpes	___Yes ___No
Cancer	___Yes ___No	Jaw Pain	___Yes ___No
Chemotherapy	___Yes ___No	Liver Disease	___Yes ___No
Ulcerative Colitis	___Yes ___No	Low Blood Pressure	___Yes ___No
Heart Problems	___Yes ___No	Psychiatric Care	___Yes ___No
Hepatitis Type ____	___Yes ___No	Respiratory Disease	___Yes ___No
Kidney Disease	___Yes ___No	Sinus Trouble	___Yes ___No
Anemia	___Yes ___No	Stroke	___Yes ___No
Arthritis, Rheumatism	___Yes ___No	Thyroid Problems	___Yes ___No
Asthma	___Yes ___No	Tuberculosis	___Yes ___No
Back Problems	___Yes ___No	Ulcer	___Yes ___No
Bleeding abnormally,	___Yes ___No	Venereal Disease	___Yes ___No
(with extractions or surgery)		Weight Loss, unexplained	___Yes ___No
Blood Disease (Transfusion)	___Yes ___No	Cold Sores	___Yes ___No

Women:

Are you pregnant? ___Yes ___No Due date: _____
Are you nursing? ___Yes ___No
Taking birth control pills? ___Yes ___No

MEDICATIONS

List of medications you are currently taking and correlating diagnosis

_____
_____
_____

NONE: (PLEASE INITIAL HERE IF NO MEDICATIONS ARE TAKEN AT THIS TIME_____)

ALLERGIES

___Aspirin
___Codeine
___Amoxicillin
___Penicillin
___Clindamycin
___Local Anesthetic
___Sulfa
___Latex
___Other _____
___**NONE**

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I will notify the doctor of any change in my health or medication.

Patient Signature:_____**Date**: _____