

PATIENT INFORMATION

Date _____ SS# _____

Patient

Name _____

Address _____

Home Phone _____

Drivers License # and State _____

Sex: M F Age _____ Birthdate _____

Occupation _____

Employer _____

Employer

Address _____

Employer

Phone # _____

Responsible Party/ Parent/ Spouse

Name _____

Birthdate _____ SS# _____

Occupation _____

Employer _____

Other family members seen by us:

The following are additional forms of communication that are optional and do not have to be filled in if one chooses not too. One's e-mail will be for newsletters from this office only and to communicate about future appointments only and will not be given out to anyone.

Cell phone _____

e-mail _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household)

(Name) _____ (Relationship) _____

(Home Phone) _____ (Work Phone) _____

MEDICATIONS

List any medication (**also herbal**) you are taking and the correlation diagnosis: _____

Pharmacy Name _____

ALLERGIES

- | | |
|-------------------------------------|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Benzocaine | <input type="checkbox"/> Metals |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Other _____ |

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

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

Bad Breath Yes No

Bleeding gums Yes No

Blisters on lips or mouth Yes No

Burning sensation

on tongue Yes No

Chew on one side

of mouth Yes No

Cigarette, pipe or cigar

smoking Yes No

Clicking or popping jaw Yes No

Dip or chew tobacco Yes No

Dry mouth Yes No

Fingernail biting Yes No

Food collection between

the teeth Yes No

Grinding teeth Yes No

Gums swollen or tender Yes No

Jaw pain or tiredness Yes No

Lip or cheek biting Yes No

Loose teeth or

broken fillings Yes No

Mouth breathing Yes No

Mouth pain, brushing Yes No

Orthodontic treatment Yes No

Pain around ear Yes No

Periodontal treatment Yes No

Sensitivity to cold Yes No

Sensitivity to heat Yes No

Sensitivity to sweets Yes No

Sensitivity when biting Yes No

Sores or growths in mouth Yes No

Tongue Bar/Mouth piercing Yes No

How often do you floss? _____

How often do you brush? _____

Do you use mouthrinse? Yes No

Type/Brand _____

Have you ever had any problems or complications with previous dental treatment?

If we could wave a magic wand and change anything about your smile, what would it be?

If we could offer you a simple, inexpensive way to whiten your teeth, would you be interested?

HEALTH HISTORY

Physician's

Name _____

Date last visit _____

Have you ever taken any of the group drugs collectively referred to as "fen-phen?" These include combinations Ionimin, Adipex, Fastin (brand names of phentemine), Pondimin (fenfluramine) and Redux (dexfenfluramine).

Yes No

Mark "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV Yes No

Anemia Yes No

Anxiety Attacks Yes No

Arthritis/Rheumatism Yes No

Artificial Heart Valves Yes No

Artificial Joints/Bones Yes No

Asthma Yes No

Back Problems Yes No

Bleeding abnormally, with
extractions or surgery Yes No

Blood Disease/Transfusions Yes No

Cancer Yes No

Chemical Dependency Yes No

Chemotherapy Yes No

Circulatory Problems Yes No

Claustrophobia Yes No

Congenital Heart Lesions Yes No

Cortisone Treatments Yes No

Cough, persistent or bloody Yes No

Diabetes Yes No

Difficult Breathing Yes No

Do you wear contact lenses? Yes No

Drug / Alcohol Abuse Yes No

Emphysema Yes No

Epilepsy / Seizures Yes No

Fainting or Dizziness Yes No

Glaucoma Yes No

Headaches Yes No

Heart Murmur Yes No

Heart Problems / Attack Yes No

Hepatitis Type _____ Yes No

Herpes Yes No

High Blood Pressure Yes No

Jaundice Yes No

Jaw pain Yes No

Kidney Disease Yes No

Liver Disease Yes No

Low Blood Pressure Yes No

Mitral Valve Prolapse Yes No

Nervous Problems Yes No

Pacemaker Yes No

Psychiatric Care Yes No

Radiation Treatment Yes No

Respiratory Disease Yes No

Rheumatic Fever Yes No

Scarlet Fever Yes No

Shortness of Breath Yes No

Sinus Trouble Yes No

Skin Rash Yes No

Special Diet Yes No

Stroke Yes No

Swollen Feet or Ankles Yes No

Swollen Neck Glands Yes No

Thyroid Problems Yes No

Tonsillitis Yes No

Tuberculosis Yes No

Tumor or growth on
head or neck Yes No

Ulcer Yes No

Venereal Disease Yes No

Weight Loss, unexplained Yes No

Women:

Are you pregnant? Yes No

Due Date _____

Are you nursing? Yes No

Taking Birth Control Pills? Yes No

Consent

I attest to the accuracy of the information I have given and I understand that this information will be held in the strictest confidence. I understand that **it is my responsibility to inform this office of any changes** in my medical status and/or address.

I authorize Dr. Barberee and associates to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also understand the use of anesthetic agents embodies certain risks and hazards for the relief and protection from pain during the planned and additional procedures. I understand certain complications may result from the use of any anesthetic including respiratory problems, drug reaction, paralysis, brain damage, or even death.

I authorize the release of any information concerning my (or my child's) health care, advise, or treatment to another doctor or to insurance companies.

I have read and understand this entire page front and back prior to signing below.

Patient Date

X _____
Person responsible for account if different from above

How did you hear about us? (Check all that apply)

Cross Timbers Phone Book (small one)

Stephenville Regional Phone Book (large one)

Empire-Tribune Newspaper

Cross Timbers Trading Post Newspaper

Referred by:

Friend Family

Co-worker Other

KSTV Radio Fiesta Radio

KCUB Radio

Office sign on Harbin Dr

Internet/Web Site

TV Commercial