PATIENT INFORMATION

Date_____ SS#_____
Patient
Name _____

Address _____

_____

Home Phone _____
Drivers License # and State

_____
Sex: □M □F Age_____ Birthdate_____
Occupation_____
Employer_____
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 to. 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 medications (also herbal) you are taking and the correlating diagnosis: _____
_____
_____
_____
Pharmacy Name_____

ALLERGIES

□Aspirin	□Latex	□Sulfa
□Benzocaine	□Local Anesthetic	□Other _____
□Codeine	□Metals	_____
□Iodine	□Penicillin	_____

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 cheeck biting	□ Yes	□ No
Loose teeth or broken fillings	□ Yes	□ No
Mouth breathing	□ Yes	□ No
Mouth pain when 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 many times do you brush? _____
Do you use mouth rinse? □ Yes □ No
Type/Brand _____
Have you ever had any problems or complications with previous dental treatment? □ Yes □ No
_____
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 of last visit_____

Have you ever taken any of the group drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), 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
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
□Century Link Phone Book
□Empire Tribune Newspaper
□Referred by: □Friend □Family □Co-worker
Name_____
□Other_____
□KSTV Radio
□Tarleton Radio
□Office sign on Harbin Dr.
□Internet/Web site
□Postcard Mailers
□Care to Share Card