



Conroe Family Dentistry



Patient Information:

Name _____ Spouse: _____

Address _____ City _____
 State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____

Preferred means of Contact by phone: Home ___ Cell ___ Work ___
 May we text you for appointment reminders? Yes ___ No ___
 Do you want to receive emailed appointment reminders? Yes ___ No ___

Date of Birth (mm/dd/year) _____ Age _____ Gender _____

Social Security Number _____
 Driver's License Number _____

Who may we thank for referring you to our practice? (Please specify)

Insurance Information:

<u>Primary Insurance Company</u>	<u>Secondary Insurance Company</u>
Company Name _____	Company Name _____
Group # _____	Group # _____
Policy/ID# _____	Policy/ID# _____
Employee _____	Employee _____
Employer _____	Employer _____
Date of Birth _____	Date of Birth _____
SS# _____	SS# _____
Insurance Phone # _____	Insurance Phone # _____
Address _____ _____ _____	Address _____ _____ _____



Conroe Family Dentistry



Emergency Contact:

Name _____	Relationship to Patient _____
Address _____	City _____
State _____	Zip _____
Home Phone _____	Cell Phone _____
	Work Phone _____

Financially Responsible Contact:

Name _____	Relationship to Patient _____
Address _____	City _____
State _____	Zip _____
Home Phone _____	Cell Phone _____
	Work Phone _____

Consent for Financial Responsibility:

- *As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred for their care.*
- *Patients understand that prior to treatment, a treatment plan will be provided with an estimate of the patient and the insurance portion. Patients also understand that in the case that insurance does not cover treatment, the patient will be full responsible for the cost of treatment.*
- *A service charge of \$25 will be billed to patients that do NOT cancel their appointment with a 24 hour notice (No Shows)*
- *I have read the above conditions of treatment/payment and agree to their content.*
- *I have provided accurate insurance/emergency/personal information and understand that I must report any changes to Conroe Family Dentistry.*

Patient/Guardian Signature _____ ***Date*** _____

Patient Print Name _____



Conroe Family Dentistry Medical History



In order for our office to provide each patient with the best possible care, please complete the Medical & Dental history below. ALL information is completely CONFIDENTIAL. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you may receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes ___ No ___ If yes, Physician's name
& Number _____

Have you ever been hospitalized or had a major operation? Yes ___ No ___ If yes, Explain

Are you currently on a special diet? Yes ___ No ___ If yes, Explain

Do you use recreational drugs? Yes ___ No ___ If yes, Explain

WOMEN:

Pregnant/Trying to get pregnant? Yes ___ No ___ If pregnant, Due Date _____

Nursing? Yes ___ No ___ Taking oral Contraceptives? Yes ___ No ___

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE BELOW CONDITIONS

(PLEASE CIRCLE ALL THAT APPLY)

- | | | | |
|----------------------------|-----------------------|------------------------|----------------------|
| -AIDS/HIV Positive | -Contact Lenses | -Heart Trouble/Disease | -Renal Dialysis |
| -Alzheimer's Disease | -Convulsions | -Hemophilia | -Rheumatic Fever |
| -Anaphylaxis | -Cortisone Medicine | -Hepatitis A | -Rheumatism |
| -Anemia | -Diabetes | -Hepatitis B or C | -Scarlet Fever |
| -Angina | -Drug Addiction | -Herpes | -Shingles |
| -Arthritis/Gout | -Easily Winded | -High Blood Pressure | -Sickle Cell Disease |
| -Artificial Heart Valve | -Emphysema | -Hives/Rash | -Sinus Trouble |
| -Artificial Joint | -Epilepsy/Seizures | -Hypoglycemia | -Spina Bifida |
| -Asthma | -Excessive Bleeding | -Irregular Heartbeat | -Stomach/Intestinal |
| -Blood Disease | -Excessive Thirst | -Kidney Problems | -Stroke |
| -Blood Transfusion | -Faint/Dizzy Spells | -Leukemia | -Swelling of Limbs |
| -Breathing Problems | -Frequent Cough | -Liver Disease | -Thyroid Disease |
| -Bruise Easily | -Frequent Diarrhea | -Low Blood Pressure | -Tonsillitis |
| -Cancer | -Genital herpes | -Lung Disease | -Tuberculosis |
| -Chemotherapy | -Glaucoma | -Migraine/Headaches | -Tumors/Growths |
| -Chest Pains | -Hay Fever | -Mitral Valve Prolapse | -Ulcers |
| -Cold Sores/Blisters | -Heart Attack/Failure | -Parathyroid Disease | -Venereal Disease |
| -Congenital Heart Disorder | -Heart Murmur | -Psychiatric Care | -Yellow Jaundice |
| | -Heart Pacemaker | -Radiation Treatment | -Other _____ |
| | | -Recent Weight Loss | |

Patient Name _____

Office Notes _____

Doctor Signature _____ Date _____



Conroe Family Dentistry Medical History



PLEASE LIST ANY MEDICATION (PRESCRIBED & OVER-THE-COUNTER), VITAMINS, AND SUPPLEMENTS YOU ARE CURRENTLY TAKING. IF YOU ALREADY HAVE A COPY OF YOUR MEDICATIONS WE'D BE HAPPY TO MAKE A COPY OF IT FOR OUR RECORDS.

Medications/Vitamins/Supplements	Reason for taking Medication

Are you allergic to any of the following? (circle)

Aspirin Penicillin Codeine Acrylic Latex Local Anesthetics

Other: _____

OFFICE NOTES:

Patient/Guardian Signature _____ Date _____

Patient Print Name _____

Doctor Signature _____ Date _____



Conroe Family Dentistry Dental History



DO YOU HAVE ANY IMMEDIATE DENTAL CONCERNS NOW? YES ___ NO ___

If yes, describe _____

ARE YOU SATISFIED WITH YOUR TEETH'S APPEARANCE? YES ___ NO ___ EXPLAIN:

DO YOU FEEL NERVOUS ABOUT HAVING DENTAL TREATMENT? YES ___ NO ___

EXPLAIN: _____

Have you ever had:

Orthodontic Treatment? Yes ___ No ___
 Oral Surgery? Yes ___ No ___
 Periodontal Treatment Yes ___ No ___
 Teeth Ground/Bite Adjust Yes ___ No ___
 Bite Plate/Mouth Guard Yes ___ No ___
 Injury to Mouth/Head Yes ___ No ___

Are any of your teeth sensitive to:

Hot or Cold? Yes ___ No ___
 Sweets? Yes ___ No ___
 Biting/Chewing Yes ___ No ___
 Odors/Bad Taste Yes ___ No ___

Do you have any of the following habits?

Clench or grind teeth while awake or asleep? Yes ___ No ___
 Bite your lips or cheeks regularly? Yes ___ No ___
 Mouth breath while awake or asleep? Yes ___ No ___
 Smoke/Chew tobacco? Yes ___ No ___

Have you experienced any of the following?

Clicking or popping of the jaw? Yes ___ No ___
 Pain (joint, ear, side of face)? Yes ___ No ___
 Difficulty opening/closing mouth? Yes ___ No ___
 Head, Neck, or Shoulder ache? Yes ___ No ___

Do your gums bleed or hurt? Yes ___ No ___

Have your parents experienced gum disease or tooth loss? Yes ___ No ___
 Have you noticed any loose teeth or change in your bite? Yes ___ No ___
 Does food tend to become caught in between your teeth? Yes ___ No ___

Patient Name _____

Office Notes



Conroe Family Dentistry



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement, but, in refusing
we will not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Conroe Family Dentistry. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS IN THE FUTURE.

Please PRINT your name

Please SIGN your name

Legal Representative Signature

Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION:

Name _____

Relationship _____

Name _____

Relationship _____

Name _____

Relationship _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM APPOINTMENTS, TREATMENT, & BILLING INFORMATION, RELAY INFORMATION ABOUT MY DENTAL HEALTH, AND/OR BEING CONTACTED ABOUT SPECIAL OFFERS** VIA:

- Cell phone
- Home phone
- Work phone
- Text message
- Email
- Mail/Postcard

OFFICE USE ONLY: As Privacy Officer, I attempted to obtain the patient's (or representatives signature on this Acknowledgement but did not because:

- It was an emergency treatment
- I could not communicate with the patient
- Patient refused to sign
- Other: _____

Signature of Privacy Officer: _____

Date: _____