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______________________________

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

____

Emergency Contact:

Name ___________________________________ Relationship to Patient ____________________

Address ____City_______________________
State_______________________Zip______________

Home Phone _______________ Cell Phone _______________ Work Phone ______________

Conroe Family Dentistry

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

Patient Name__________________________

Office Notes________________________________ Doctor Signature________________________________Date____________________
____
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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: ______________________

PHARMACY NAME: ______________________ PHONE # ______________________

ADDRESS: ______________________

OFFICE NOTES:

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Patient/Guardian Signature ______________________ *Date* ____________

Patient Print Name ______________________

Doctor Signature ______________________ Date ____________

 ASA________ (OFFICE USE ONLY)

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**

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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 bud 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:____________________