1st Care DENTAL

29110 US Hwy 290 Suite 200 Cypress, TX 77433

(281) 256 - 7331

WELCOME

*We are pleased to welcome you to our practice. Please take a few moments to complete **ALL** pages of this form. If you have any questions, we'll be glad to assist you.*

Patient Information

Name _____ Nickname _____
Last First Middle
Address _____ Soc.Sec. #_____
City _____ State _____ Zip _____ Home Phone _____
Birthdate _____ Age _____ Sex: [ ] M [ ] F Cell Phone _____
[ ] Minor [ ] Single [ ]Married [ ] Widowed [ ]Separated [ ]Divorced Email _____
Employer/Occupation _____ Work Phone _____
Business Address _____
Full-time students: Name of School/College_____ City/State _____
Whom may we thank for referring you?
_____
Notify in case of emergency _____ Home phone _____ Work Phone _____

Person Responsible for Account (if patient is a minor)

Name _____ Soc.Sec.# _____
Last First Middle
Address _____ Phone _____
Relation to Patient _____ Birthdate _____ Age _____ DL# _____
[ ] Single [ ] Married [ ] Widowed [ ] Separated [ ] Divorced Sex: [ ] M [ ] F
Employer _____ Work Phone _____

Insurance Information

Name of Subscriber

_____
Last First Middle
Relation to Patient _____ Birthdate _____ Soc.Sec.# _____
Address (if different from Patient) _____
Employer _____ Work Phone _____
Employer's Address _____
Insurance Co. _____ Phone _____
Group# _____ Union/Local# _____

Secondary Insurance

Name of subscriber
_____
Last First Middle
Relation to Patient _____ Birthdate _____ Soc.Sec.# _____
Address (if different from Patient) _____
Employer _____ Work Phone _____
Employer's Address _____
Insurance Co. _____ Phone _____
Group # _____ Union/Local# _____

Dental History

Reason for Today's visit _____

Former Dentist _____ Phone _____ Date of last dental x-rays _____

Check (√) if you have any of the following :

[ ] Bad Breath
[ ] Bleeding gums
[ ] Clicking or popping jaw
[ ] Grinding teeth
[ ] Loose teeth or broken fillings
[ ] Periodontal Treatment
[ ] Food collection between teeth
[ ] Sores or growths in your mouth
[ ] Sensitivity

Medical History

Physician's Name (or Facility Name) _____ Phone _____
Have you had any serious illnesses or operations? [ ]No [ ]Yes Describe _____
Women: Are you pregnant? [ ]No [ ]Yes Nursing? [ ]No [ ]Yes Taking birth control pills? [ ]N [ ]Y
Check (√) if you have had any of the following:

__ Artificial joints
__ Kidney Disease
__ Rheumatic/Scarlet Fever
__ Heart murmur
__ Heart pacemaker
__ Liver Disease
__ Chemical Dependency
__ Thyroid disease
__ Glaucoma
__ Artificial Heart valve
__ Stroke
__ Hepatitis
__ Tuberculosis
__ Blood Transfusion
__ AIDS/HIV positive
__ Heart attack
__ Cancer

Other heart condition?
_____

__ Chemotherapy/Radiation
__ Arthritis, Rheumatism
__ Diabetes
__ Jaw pain
__ High Blood Pressure
__ Fainting/dizzy spells
__ Hemophilia
__ Psychiatric care
__ Ulcers
__ Sinus trouble
__ Angina Pectoris
__ Emphysema
__ Latex allergy
__ Cortisone Treatments
__ Tobacco habit
__ Anemia/Sickle Cell Disease
__ Asthma
__ Epilepsy/seizures

List all medications you are currently taking:
_____
_____
_____

List drug allergies:
_____
_____
_____

Authorization and Release

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my medical status. I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all my insurance submissions. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment.

Print Name _____

Signature _____ **Date** _____