NEW PATIENT INFORMATION

ADVANCED IMPLANT
& COSMETIC DENTISTRY

9292 Warren Pkwy. #380   Frisco TX 75035

TEL: (469) 362-6088

We look forward to having you join our great family of friends and patients. The benefits of a healthy, beautiful smile are immeasurable and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so we may provide the best care possible for you. All information is completely confidential.

PATIENT INFORMATION

Patient's Name_____ Date _____
               Last   First   Middle

Address _____
          Street   City   State   Zip

Home Phone_____ Birthdate_____ Social Security # _____

Parent or guardian (if patient is a dependent) _____

Work Phone_____ Cell_____ Email _____

RESPONSIBLE PARTY INFORMATION

Name _____
       Last   First   Middle

Residence _____
            Street   City   State   Zip

Mailing Address _____
                  Street   City   State   Zip

How long at this address?_____ Home Phone_____ Work Phone _____

Previous Address (if less than 3 years)_____
                                        Street   City   State   Zip

Social Security #_____ Birthdate_____ Relationship to Patient _____

Driver's License #_____ Is this person currently a patient in our office? ☐ Yes ☐ No

Employer_____ Occupation_____ # Years Employed ___

Employer Address _____
                  Street   City   State   Zip

GETTING TO KNOW YOU

What name do you go by? _____

Is a member of your family or relative a patient of our office? Name_____ Relationship_____

Whom may we thank for referring you to our office?_____

　　　　We value the confidence our patients and others place in our office and wish to recognize them for their referrals.)

Person to contact for emergency_____ Phone _____

Address _____
          Street   City   State   Zip

Name of nearest relative not living with you_____ Phone _____

Address _____
          Street   City   State   Zip

Confidential Health History Form

Today's Date _____

Patient Name: First _____ MI _____ Last _____ Date of Birth _____

I. Circle appropriate answer (Leave blank if you do not understand the question)

1. Yes / No   Is your general health good?
   If NO, explain _____

2. Yes / No   Has there been a change in your health within the last year?
   If YES, explain _____

3. Yes / No   Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain _____

4. Yes / No   Are you being treated by a physician now?
   If YES, explain _____

   Date of last medical exam? _____ Reason for exam _____

5. Yes / No   Have you had problems with prior dental treatment?
   If YES, explain _____

   Date of last dental exam _____ Name of last treating dentist _____

6. Yes / No   Are you in pain now?
   If YES, explain _____

II. Have you experienced any of the following? (Please circle Yes or No for each)

Yes / No	Chest pain (angina)	Yes / No	Blood in stools	Yes / No	Frequent vomiting
Yes / No	Fainting spells	Yes / No	Diarrhea or constipation	Yes / No	Jaundice
Yes / No	Recent significant weight loss	Yes / No	Frequent urination	Yes / No	Dry mouth
Yes / No	Fever	Yes / No	Difficulty urinating	Yes / No	Excessive thirst
Yes / No	Night sweats	Yes / No	Ringing in ears	Yes / No	Difficulty swallowing
Yes / No	Persistent cough	Yes / No	Headaches	Yes / No	Swollen ankles
Yes / No	Coughing up blood	Yes / No	Dizziness	Yes / No	Joint pain or stiffness
Yes / No	Bleeding problems	Yes / No	Blurred vision	Yes / No	Shortness of breath
Yes / No	Blood in urine	Yes / No	Bruise easily	Yes / No	Sinus problems

III. Have you had or do you have any of the following? (Please circle Yes or No for each)

Yes / No	Heart disease	Yes / No	Cosmetic surgery	Yes / No	Eating disorders
Yes / No	Family history of heart disease	Yes / No	Surgeries	Yes / No	Osteoporosis
Yes / No	Heart attack	Yes / No	Hospitalization	Yes / No	Thyroid disease
Yes / No	Artificial joint	Yes / No	Diabetes	Yes / No	Asthma
Yes / No	Stomach problems or ulcers	Yes / No	Family history of diabetes	Yes / No	Hepatitis
Yes / No	Heart defects	Yes / No	Tumors or cancer	Yes / No	Sexual transmitted disease
Yes / No	Heart murmurs	Yes / No	Chemotherapy	Yes / No	Herpes
Yes / No	Rheumatic fever	Yes / No	Radiation	Yes / No	Canker or cold sores
Yes / No	Skin disease	Yes / No	Arthritis, rheumatism	Yes / No	Anemia
Yes / No	Hardening of arteries	Yes / No	Emphysema or other lung disease	Yes / No	Liver disease
Yes / No	High blood pressure	Yes / No	Kidney or bladder disease	Yes / No	Eye disease
Yes / No	Seizures	Yes / No	Stroke	Yes / No	Transplants
				Yes / No	Tuberculosis

This information will not be released unless specifically authorized by patient.

Yes / No   AIDS/HIV   Yes / No   Anxiety   Yes / No   Depression   Yes / No   Treatment for emotional condition

IV. Are you allergic to or have you had a reaction to any of the following? (Please circle Yes or No for each)

Yes / No	Aspirin	Yes / No	Valium	Yes / No	Tetracycline
Yes / No	Darvon	Yes / No	Demerol	Yes / No	Vicodin
Yes / No	Codeine	Yes / No	Penicillin	Yes / No	Percodan
Yes / No	Latex	Yes / No	Food	Yes / No	Nitrous oxide
Yes / No	Local anesthetic (Novocain or Xylocaine)	Yes / No	Erythromycin	Yes / No	Metal

Others _____

V. Are you taking or have you taken any of the following in the last three months? *(Please circle Yes or No for each)*

Yes / No   Recreational drugs
Yes / No   Over-the-counter medicines
Yes / No   Weight loss medications
Yes / No   Cortico - Steroids

Yes / No   Tobacco in any form
Yes / No   Alcohol
Yes / No   Bisphosphonate (Fosamax)

Yes / No   Antibiotics
Yes / No   Supplements
Yes / No   Aspirin

Please list all medications you are currently taking_____

VI. Women only *(Please circle Yes or No for each)*

Yes / No   Are you or could you be pregnant? If YES, what month?_____
Yes / No   Are you nursing?
Yes / No   Are you taking birth control pills?

VII. All patients *(Please circle Yes or No for each)*

Yes / No   Do you have or have you had any other diseases or medical problems NOT listed on this form?
           If YES, explain_____
           _____

Yes / No   Have you ever been pre-medicated for dental treatment?
           If YES, why_____

Yes / No   Have you ever taken Fen-Phen?
           If YES, when_____

Yes / No   Is there any issue or condition that you would like to discuss with the dentist in private?

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature_____ Date_____

Physician's Name_____ Phone Number_____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____   _____ _____
Signature of Patient (Parent or Guardian)   Date   Signature of Dentist   Date

Medical updates

I have reviewed my Health History and confirm that it accurately states past and present conditions.

Date	Patient Signature	Changes to Health History	Dentist Initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____