Dallas Dental Care

Today's Date _____ Home Phone_____
Work Phone_____
Cell Phone_____

Name_____ Name to be called_____

E-Mail Address_____ County of Residence_____

SSN_____ Date of Birth_____ Age_____ Sex: M F

Home Address_____ City_____ State _____ Zip_____

Billing Address_____ City _____ State _____ Zip _____

Occupation_____Employer_____PhoneNumber_____

Employer Address _____

Marital Status _____ Spouse Name _____ Spouse DOB _____ Spouse SSN_____

Spouse's Employer _____

Spouse's Employer Address_____ Business Phone _____

X **Person Financially Responsible** _____ Relationship to you _____

Your Children's Names and Ages ___ _____

Primary Dental Insurance Information

Name of Insured _____Relationship to Patient _____

Insured DOB _____SSN _____

Employer _____Employer Address_____

Dental Ins. Co._____ Group #_____ Tele #_____

Secondary / Additional Dental Insurance

Name of Insured _____ Relationship to Patient _____

Insured DOB _____ SSN _____

Employer _____Employer Address_____

Dental Ins. Co._____ Group #_____ Tele #_____

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

Primary Physician_____City_____

Conditions being treated_____

Current Medications (list all)_____

Preferred Pharmacy_____

Y N Is your general health good?
Y N Have you been hospitalized in the last 5 years? What reason_____?
Y N Are you pregnant? Week #_____
Y N Have you ever had any joint replacements (hip, knee, elbow, etc?)
Y N Have you ever taken any biophosphonates such as Fossamax or Actonel? (for osteoporosis or Paget's disease)
Y N Have you ever had cancer? Type_____ When?_____
Y N Has a physician or dentist recommended that you take antibiotics prior to dental treatments for a heart condition, joint replacement, or a medical condition?
Y N Do you have an artificial heart valve or damaged heart valve?
Y N Are you allergic to latex?
Y N Are you allergic to any medications?
If yes, list allergies_____

Please mark if you have or have had any of the following conditions:

( ) Diabetes	( ) High Blood pressure/Hypertension
( ) Chronic sinus problems	( ) Hepatitis
( ) Sickle Cell Anemia	( ) Excessive Bleeding
( ) Asthma	( ) Thyroid Disease
( ) Epilepsy/Seizures	( ) Artificial joint such as hip, knee
( ) HIV Positive	( ) Severe headaches/migraines
( ) Heart Problems	( ) Bleeding Gums
( ) Heart Murmur	( ) Cold Sensitive teeth or painful teeth
( )Smoke/Tobacco Use	( ) Nervous Disorder
( ) Drug/Alcohol Use	

Have you ever worn a partial or denture?	Y	N
Are you happy with the color of your teeth?	Y	N
Does your home have its own well for water?	Y	N

(A) It is understood that all records, appliances, models, radiographs and photographs taken in and during the examination and treatment remain in the property of Dallas Dental Care.

(B) I understand that all payments are due at the time service is rendered, unless other arrangements have been made in advance. Dallas Dental Care has my permission to run a credit check. Should I fail to fully comply with any financial arrangements, I agree to pay financial charges that will be added to my account. I understand that if my account is taken before a collection agency or attorney for any reason, I am responsible for ALL collections and/or attorney fees.

(C) Dallas Dental Care has my permission to verify employment information for me and my spouse.

X ***Signature:*** _____ ***Date:***_____