CENTRAL TEXAS DENTAL CARE
506 North Hewitt Drive-Hewitt 76643
254.666.1686/Fax: 254.666.9252

PATIENT INFORMATION:

Patient's Full Name: ____Date:_________________________________

Address: ____City:_____________________State:_______Zip:__________

Home Phone: ___________________Work Phone: _____________________Cell Phone: ___________________________

Date of Birth: _____________________________Social Security Number: _______________________________________

Driver's License Number: _______________________ Email: ____

Whom may we thank for referring you? ____

Name & Address of person responsible for this account: ____

____Social Security Number: __________________________

Other immediate family members treated in this office:____

DENTAL INSURANCE INFORMATION:

Subscriber's Name: ____

Date of Birth: _____________________________________Social Security Number: ________________________________

Employer Name: ______________________________________ Insurance Co. ____________________________________

ID Number: __________________________________ Group Number: ____

DENTAL HISTORY:

The following information is needed for treatment to protect your general health and will be held in the strictest confidence.

1. Does dental treatment make you nervous? ____

2. Would you prefer to be sedated should you need dental work? _______________________________________

3. Is there anything that you would like to change about any of your teeth or your dental smile?
____

4. Would you like to have whiter teeth? ____

5. Do you have any jaw joint problems?
   - ☐ Clicking or popping when opening or closing
   - ☐ Difficulty opening or closing jaw
   - ☐ Clenching or grinding
   - ☐ Excessive tooth wear
   - ☐ Pain in the jaw joint
   - ☐ Headaches
   - ☐ Ringing in the ears

6. Do you wear any type of Sleep appliance/C-Pap, TMJ appliance, or any other type of appliance?
____

Medical History:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐Yes ☐No Describe: ___________________________________
Have you ever been hospitalized or had a major operation? ☐Yes ☐No Describe:
____
Have you ever had a serious head or neck injury? ☐Yes ☐No Describe: ___________________________
Are you taking any medications, pills, drugs? ☐Yes ☐No Describe:
____
Do you take, or have you taken, Phen-Fen or Redux? ☐Yes ☐No
Do you use tobacco? ☐Yes ☐No
Do you use controlled substances? ☐Yes ☐No
Are you on a Special Diet? ☐Yes ☐No

Women: Are you Pregnant/Trying to get pregnant: ☐Yes ☐No Taking Oral Contraceptives: ☐Yes ☐No
Nursing: ☐Yes ☐No

Are you allergic to any of the following: ☐ Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐Local Anesthetics ☐Other- If yes, Describe: ____

Do you have, or have you had, any of the following?

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

Have you ever had any serious illness not listed above? ☐Yes ☐No Describe: ___________________________
____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN: ____

Relation to Patient: ____**Date:**____________________