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	ə:	Cell Phone:			
Date of Birth:	Social Security Number	r:			
Driver's License Number:	Email:				
Whom may we thank for referring you?					
Name & Address of person responsible for this a	ccount:				
	Social Se	ecurity Number:			
Other immediate family members treated in this	office:				
DENTAL INSURANCE INFORM	IATION:				
Subscriber's Name:					
Date of Birth:	Social Security	Number:			
Employer Name:	Insurance	e Co			
ID 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 Difficulty opening or closing jaw Clenching or grinding Excessive tooth wear Pain in the jaw joint Headaches Ringing in the ears			li G		
6. Do you wear any type of Sleep appliance/	C-Pap, TMJ applian	ce, or any other type of ap	pliance?		

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 had a serious head or neck injury? □Yes □No Describe: Have 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 tobacco? □Yes □No Momen: Are you Pregnant/Trying to get pregnant: □Yes □No Taking Oral Contraceptives: □Yes □No Are you on a Special Diet? □Yes □No Momen: 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: □Yes, □Describe: □Do you have, or have you had, any of the following? □Ads/HIV Postitve □ Alds/HIV Postit	Medical History:						
Have you ever had a serious head or neck injury? Yes No Describe: Are you taking any medications, pills, drugs? Yes No Describe:	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.						
Have you ever had a serious head or neck injury? Yes No Describe: Are you taking any medications, pills, drugs? Yes No Describe:	Are you under a physician	a's care now? □Yes □No De	escribe:				
Are you take, or have you taken, Phen-Fen or Redux? Yes No Do you use tobacco? Yes No Do you use tobacco? Yes No Do you use controlled substances? Yes No Are you on a Special Diet? Lyes 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?	Have you ever been hospitalized or had a major operation? □Yes □No Describe:						
Are you take, or have you taken, Phen-Fen or Redux? Yes No Do you use tobacco? Yes No Do you use tobacco? Yes No Do you use controlled substances? Yes No Are you on a Special Diet? Lyes 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?	Have you ever had a serio	us head or neck injury? □Y	es □No Describe:				
Do you use tobacco?							
Do you use tobacco?	Do you take, or have you t	aken, Phen-Fen or Redux?	' □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	Do you use tobacco? □Yes	s□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 Yes No Nursing: Yes No Taking Oral Contraceptives: Yes No Nursing: Yes No Yes No Nursing: Yes No Taking Oral Contraceptives: Yes No Nursing: Yes Nursi	Do you use controlled sub	stances? □Yes □No					
Women: Are you Pregnant/Trying to get pregnant: Yes No Taking Oral Contraceptives: Yes No Nursing: Yes Nursing:							
Anesthetics Other- If yes, Describe:	Women: Are you Pregnant/Trying to get pregnant: □Yes □No Taking Oral Contraceptives: □Yes □No Nursing: □Yes □No						
Anesthetics Other- If yes, Describe:	Are you allergic to any of	f the following: Asnirin F	Penicillin ⊐Codeine ⊐∆crylic ⊐	Metal □Latev □Local			
Alds/HIV Positive							
Alds/HIV Positive	· · · · · · · · · · · · · · · · · · ·						
Alzheimer's Disease Diabetes Hepatitis A Rheumatic Fever Anaphylaxis Drug Addiction Hepatitis B or C Rheumatism Scarlet Fever Rheumatism Hepatitis A Hepatitis B or C Rheumatism Resily Winded Herpes Scarlet Fever Scarlet Fever Shingles Sickle Cell Disease Artificial Heart Valve Excessive Bleeding Hypoglycemia Sinus Trouble Spina Bifida Stinus Trouble Spina Bifida Stomach / Intestinal Sinus Trouble Spina Bifida Stomach / Intestinal Sinus Bida Stomach / Intestinal Sinus Bida Stomach / Intestinal Disease Stroke S	Do you have, or have you						
□ Anaphylaxis □ Anemia □ Angina □ Angina □ Anthritis/Gout □ Epilepsy or Seizures □ Artificial Heart Valve □ Artificial Joint □ Excessive Bleeding □ Hypoglycemia □ Hirves or Rash □ Sinus Trouble □ Spina Bifda □ Sinus Trouble □ Sinus Trouble □ Spina Bifda □ Sinus Trouble □ Sinus Trouble □ Spina Bifda □ Spi	☐ Aids/HIV Positive		<u> </u>	-			
Anemia	☐ Alzheimer's Disease						
Angina	☐ Anaphylaxis						
Artificial Gout	□ Anemia						
Artificial Heart Valve							
Artificial Joint	☐ Arthritis/Gout						
Asthma							
□ Blood Transfusion □ Breathing Problem □ Breathing Problem □ Bruise Easily □ Cancer □ Chemotherapy □ Chest Pains □ Cold Sores/Fever Blisters □ Congenital Heart Murmur □ Heart Murmur □ Heart Trouble/Disease □ Convulsions □ Convulsions □ Tuberculosis □ Heart Trouble/Disease □ Radiation Treatment □ Recent Weight Loss □ Swelling of Limbs □ Stroke □ Swelling of Limbs □ Thyroid Disease □ Thyroid Disease □ Tonsillitis □ Tuberculosis □ Tumors or Growths □ Parathyroid Disease □ Radiation Treatment □ Recent Weight Loss □ Venereal Disease □ Yellow Jaundice □ 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.				1 -			
Breathing Problem							
□ Bruise Easily □ Cancer □ Chemotherapy □ Chest Pains □ Cold Sores/Fever Blisters □ Congenital Heart Disorder □ Convulsions □ Convulsions □ Tuberculosis □ Venereal Disease □ Venereal Disease □ Yellow Jaundice □ 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.							
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□ Chemotherapy □ Chest Pains □ Cold Sores/Fever Blisters □ Congenital Heart □ Disorder □ Convulsions □ Convulsions □ Heart Trouble/Disease □ Pain in Jaw Joints □ Pain in Jaw Joints □ Parathyroid Disease □ Psychiatric Care □ Radiation Treatment □ Recent Weight Loss □ Venereal Disease □ Yellow Jaundice □ Yellow Jaundice □ 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.		_					
□ Chest Pains □ Cold Sores/Fever Blisters □ Congenital Heart □ Congenital Heart □ Convulsions □ Heart Attack/Failure □ Heart Murmur □ Heart Pace-Maker □ Heart Trouble/Disease □ Radiation Treatment □ Recent Weight Loss □ Venereal Disease □ Yellow Jaundice □ 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.							
□ Cold Sores/Fever Blisters □ Congenital Heart □ Heart Pace-Maker □ Heart Trouble/Disease □ Convulsions □ Heart Trouble/Disease □ Radiation Treatment □ Recent Weight Loss □ Yellow Jaundice □ 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.		· ·					
□ Congenital Heart □ Convulsions □ Heart Pace-Maker □ Heart Trouble/Disease □ Radiation Treatment □ Recent Weight Loss □ Yellow Jaundice □ 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.							
Disorder Convulsions Heart Trouble/Disease 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.							
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Relation to Patient: Date:	Relation to Patient:	I AMENI, OR GUARDIAN;					