6658 Summer Fest Ste 104
San Antonio, TX 78244
(210)661-6401

Welcome to the office! Please complete front and back...don't worry everything is confidential

PATIENT INFORMATION

Name:_____Preferred Name:_____
First Middle Initial Last
Date of Birth:___/___/_____ Sex: M__ F __ Email:_____
Address:_____
Street Name and Number Apt# City State Zip
Best Contact Phone Numbers: (___) ____ - _____ (____) ____ - _____
Emergency Contact: _____ (____) ____ - _____
Name Phone number
Email:_____
What is you preferred method of confirming your appointments? Phone____Email ____Text____
How did you hear about the office?_____

ACCOUNT INFORMATION

Who is financially responsible for this account? _____
First Middle Initial Last
Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscribers Information

Subscriber Name_____Subscriber ID # _____
Insurance Company _____Phone_____
Employer_____Group Name_____Group #_____
Date of Birth_____Social Security Number_____

DENTAL HISTORY

Are you having immediate dental problems? _____If so, please explain: _____
When was your last visit to the Dentist? _____
When were your teeth cleaned last? _____
Who was your last Dentist? _____
Are you satisfied with your past dentistry? ___Yes ___No
How many times a week do you brush your teeth? _____ Floss? _____

Has fear or discomfort kept you from seeing a dentist on a regular basis?	Yes	No
Do your gums bleed easily, feel tender or irritated?	Yes	No
Are your teeth sensitive to hot, cold or sweets?	Yes	No
Do your jaws feel tired?	Yes	No
Do you have pain in the head, neck, shoulders or back?	Yes	No
Do you have clicking or popping noises when opening or closing your mouth?	Yes	No
Are you aware of grinding or clenching your teeth?	Yes	No

Kids n More DENTIST
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If so, do you wear a night guard? Yes No
Would you prefer to use the nitrous oxide (laughing gas)? Yes No

Medical History

Are you being treated by a physician now? Yes No Reason_____
Physician's Name:_____ Office Phone Number: (____) ____-_____
Address:_____ City:_____ State: _____Zip: _____
Is the patient taking any medication? Yes No
Identify:_____
Is the patient allergic to any medication? Yes No
Identify:_____
Is the patient allergic to metals? Yes No
Identify:_____
Has the patient had any serious illnesses? Yes No
Identify:_____
Has the patient had any surgeries? Yes No
Identify:_____

Circle all that Apply

AIDS (HIV Positive)	Eye Disorders	Radiation Treatment
Allergic to Penicillin	Fainting/Dizzy spells	Rheumatic Fever
Arthritis	Glaucoma	Smoking/Smokeless Tobacco
Artificial Heart Valve	Heart murmur	Stomach/intestinal Problems
Artificial Joints	Heart Pacemaker	Stroke
Asthma	Heart Trouble	Thyroid Condition
Birth Control Pills	Hepatitis	Tuberculosis
Bruise Easily	High Blood Pressure	Tumors/growths
Cold Sores/Fever Blisters	Kidney/Liver Disorder	Ulcers
Currently Pregnant	Latex Sensitivity	Venereal Disease
Diabetes	Prolonged Bleeding	
Epilepsy	Psychiatric/Psychological Care	

Are there any other medical problems that we should be aware of? Yes No
If yes, please explain:_____

Consent For Treatment

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the Doctor of any change in my health or medications.

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Upon such diagnosis, I authorize the Doctor to perform all recommended treatment mutually agreed upon by me to employ such assistance as required to provide proper care.

I agree to use the anesthetic, sedatives, and other medications as prescribed, I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Lastly, I agree to be responsible for payment of all services on my behalf or my dependants. I understand that payment is due at the time of services unless other arrangements have been made prior to the services being rendered.

Patient Signature:_____Date:_____

Parent/Responsible Party Signature: _____Date:_____