Creekside Dental

17159 FM 2493
Flint, TX 75762
Phone: (903) 894-6064 Fax: (903) 894-6057

HEALTH HISTORY & REGISTRATION

PATIENT INFORMATION

PATIENT'S NAME: Last ________ First ________ MI ____ SEX: M/F Birth date: ________ Age: ____
If patient is a Minor, give Parent's or Guardian's Name ________ Reason for this Visit ________
Who May We Thank for Referring You to our Office? ________ Today's Date ________

RESPONSIBLE PARTY INFORMATION

Name: Last ________ First ________ MI ____ Marital Status ________
Residence: Street ________ City ________ State ________ Zip ________
Mailing Address: Street ________ City ________ State ________ Zip ________
How Long At This Address: ________ Home Phone ________ Work Phone ________
Social Security # ________ Birth date ________ Driver's License # ________ Relation To Patient ________
Employer ________ Occupation ________ No. Years Employed ________

SPOUSE'S INFORMATION

SPOUSE'S NAME ________
EMPLOYER ________
OCCUPATION ________
WORK PHONE ________ BIRTH DATE ________

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU

NAME ________
ADDRESS ________
CITY, STATE ________ Phone ________

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured Name
Insurance Co. ________
Insurance Co. Address ________
Insured Employer ________
Insured's ________
Soc. Sec. # ________ Group # ________ Local# ________

If you have additional dental insurance coverage, complete this for the secondary.

Insured Name ________
Insurance Co ________
Insurance Co. Address ________
Insured Employer ________
Insured's ________
Soc. Sec. # ________ Group # ________ Local# ________

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

*DENTAL HISTORY	YES	NO
HOW LONG SINCE you have seen a Dentist?		
Last COMPLETE dental exam date		
Last FULL MOUTH X-RAYS date		
Are you having PROBLEMS now?	☐	☐
WHAT?		
Is your present dental health POOR?	☐	☐
Do you wear DENTURES?(Partials or Full)	☐	☐
Are you UNHAPPY with your dentures?	☐	☐
Would you like to know more about Permanent Replacements?	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐
Have you had any PERIODONTAL (GUM) Treatments?	☐	☐
Do your gums BLEED or feel TENDER or IRRITATED?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets, pressure?(circle)		
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES or NECK PAINS?	☐	☐
Have you worn BRACES on you teeth?(ORTHODONTICS)	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
Would you like your smile to Look Better or Different?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐

Name of previous Dentist

City State

How do you feel about your teeth?

Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.

FEAR of Pain	#	LACK of concern	#
COST of treatment	#	MISSING work time	#

*MEDICAL HISTORY	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIANS CARE now?	☐	☐
For What?		
What MEDICATIONS are you currently taking?		
Are you PREGNANT?	☐	☐
Do you SMOKE?	☐	☐

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR PRESENTLY HAVE:

Heart Disease or Attack	A.I.D.S./A.R.C./HIV Pos	Bruise Easily
Angina Pectoris	Hepatitis A (infectious)	Emphysema
High Blood Pressure	Hepatitis B (serum)	Tuberculosis (TB)
Heart Murmur	Liver Disease	Asthma
Rheumatic Fever	Blood Transfusion	Hay Fever
Congenital Heart Lesions	Drug Addiction	Sinus Trouble
Mitral Valve Prolapse	Hemophilia (Bleeding Problems)	Allergies or Hives
Artificial Heart Valve	Fever Blisters	Diabetes
Heart Pacemaker	Epilepsy or Seizures	Thyroid Disease
Heart Surgery	Nervousness	Radiation Treatment
Artificial Joints (Hip, Knee)	Psychiatric Treatment	Arthritis
Anemia	Glaucoma	Cortisone Medicine
Stroke	Chemotherapy (Cancer, Leukemia)	Pain in Jaw Joints
Kidney Trouble	Venereal Disease (Syphilis, Gonorrhea, etc.)	Alcoholism
Ulcers		Cosmetic Surgery
Organ Transplant		

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin	Local Anesthetic	Erythromycin
Nitrous Oxide	Codeine	Penicillin

Are you aware of being allergic to any other medications or substances? ☐ Y ☐ N

If yes, please list ________
Is there any other Medical or Dental information that you feel I should know about?

____

FAMILY PHYSICIAN ________ PHONE NO. ________

CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostics aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a finance charge will be added to any overdue balance.

PATIENT SIGNATURE (Parent of Child) ________ Date ________