# AUSTIN FAMILY DENTAL

**PATIENT INFORMATION**

First Name: _____ Last Name: _____ Preferred Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Birth Date: _____ SSN: _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Other

Cell Phone #_____ Home Phone #_____

Email: _____

Would you like access to our online payment portal? ☐ Y ☐ N * If yes, provide email address above

How did you hear about us?

**RESPONSIBLE PARTY** *If different than above ☐ Spouse ☐ Parent ☐ Other

Name:_____ Birth Date: _____

Address:_____

City:_____ State: _____ Zip: _____ Phone: _____

**IN CASE OF EMERGENCY CONTACT**

Name:_____Relationship: _____ Phone # : _____

CONSENT FOR TREATMENT, INSURANCE, FINANCIAL, and APPOINTMENT POLICIES

I hereby authorize the administration of such medications and performance of such diagnostic and therapeutic procedures as may be necessary for proper dental care. The undersigned hereby authorizes Doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patients' dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapies that may be indicated and further authorize and consent that the Doctor choose and employ such assistance as he deems fit. I authorize the use of my signature on all insurance claims.

I understand that responsibility for payment of dental services provided in this office for myself or my dependents is mine, and is due at the time services are rendered, unless prior financial arrangements have been made. We accept payments in the form of cash, check, Visa, MasterCard, Discover, American Express, and Care Credit. I further understand that a 1.5% finance charge (18% annually) will be added to any balance over 60 days. In the event of default (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. Any returned checks are subject to a fee of $30. We do require a 24 - hour notice on all canceled or failed appointments or you will be subject to a fee of $50.

 Signature _____ Date _____

**MEDICAL HISTORY**

Patient Name Date of Birth

Name of Physician / Medical facility:

Has there been any changes in your health in the past year? ☐ Yes ☐ No

Have you had a serious illness, operation, or have been hospitalized in the last 5 years? ☐ Yes ☐ No

Do you use tobacco (smoke/chew)? ☐ Yes ☐ No If yes, what type and how often

**ALLERGIES** Mark (X) if you currently have any of the following allergies

☐ Latex ☐ Codeine ☐Penicillin ☐ Local anesthetic ☐ Metals ☐ Sulfa drugs ☐ Other _____

Have you ever had a joint replacement (hip, knee, shoulder, elbow, finger, etc.)? ☐Yes ☐No

Do you need to take antibiotic premedication prior to dental treatment? ☐ Yes ☐ No

Women are you taking birth control, pregnant, breastfeeding, or trying to get pregnant? ☐Yes ☐No

Are you taking a bisphosphonate bone medication such as; Fosamax, Alendronate, Boniva or Actonel ☐Yes ☐No

**MEDICATION** List all medication and vitamins that you are currently taking

Mark (X) if you have any of the following health problems — now or in the past

☐ Artificial joint
☐ Congenital heart disease
☐ Cardiovascular disease
☐ Angina (chest pain)
☐ Arteriosclerosis
☐ Congestive heart failure
☐ Heart attack
☐ Heart murmur
☐ Low blood pressure
☐ High blood pressure
☐ Heart valve defects
☐ Mitral valve prolapse
☐ Pacemaker
☐ Rheumatic fever
☐ Rheumatic heart disease
☐ Abnormal bleeding
☐ Anemia
☐ Blood Transfusion
If yes, date:_____
☐ Hemophilia

☐ Autoimmune disease
☐ Rheumatoid arthritis
☐ Systemic lupus erythematosus
☐ Asthma
☐ Bronchitis
☐ Emphysema
☐ Sinus trouble
☐ Tuberculosis
☐ Chest pain upon exertion
☐ Chronic pain
☐ Diabetes Type I or II
☐ Eating disorder
☐ Malnutrition
☐ Gastrointestinal disease
☐ G.E. reflux/ persistent heartburn
☐ Ulcers
☐ Thyroid problems
☐ Stroke
☐ Glaucoma
☐ Hepatitis, jaundice, or liver disease
☐ AIDS or HIV

☐ Arthritis
☐ Epilepsy
☐ Fainting spells or seizures
☐ Neurological disorders
If yes, specify:_____
☐ Sleep disorder
☐ Do you snore?
☐ Mental health disorders
If yes, specify:_____
☐ Recurrent infections
If yes, specify:_____
☐ Kidney problems
☐ Night sweats
☐ Osteoporosis
☐ Persistent swollen glands in neck
☐ Severe headaches/ migraines
☐ Severe or rapid weight loss
☐ Excessive urination
☐ Cancer/ chemotherapy/ radiation treatment

**DENTAL HISTORY**

Patient Name Date of Birth

Date of your last dental exam:

What was done at that last exam?

Date of last dental x-rays:

Type of last dental x-rays taken:

Mark (X) if you currently have any of the following dental problems

☐ Bad breath
☐ Bleeding gums
☐ Dry Mouth
☐ Food collection between teeth
☐ Sore, lump, or growth
☐ Do you have an Earache or neck pain?
☐ Sensitivity to cold, hot, sweets, chewing sensitivity
☐ Gum disease (now or in the past) have you had periodontal treatments ☐ Yes ☐ No
☐ Have you had orthodontic (braces) treatment
☐ Do you wear dentures or partials?
☐ Have you had problems with previous dental treatment?
☐ Clicking or popping jaw
☐ Serious head or mouth injury
☐ Grinding teeth/ clenching
☐ Dental pain
☐ Difficulty opening or closing
☐ Loose teeth
☐ Broken fillings

What is the reason for your dental visit today?

How do you feel about your smile?

Are you nervous for dental treatment?
☐ Yes ☐ No