Kerrville Family Dental

Date:_____Patient Name:_____Preferred Name:_____

Sex: M / F Age:_____ DOB_____Single/ Married/ Widowed/ Seperated/ Divorced

Patient SSN:_____Occupation:_____Employer:_____

Physical Address:_____City_____State___Zip_____

Mailing Address:_____City_____State__Zip_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Email:_____Preferred form of contact(Circle): Home / Cell/ Work/ Email/ Text

Parent/ Spouse Name:_____DOB:_____SSN_____

Occupation:_____Parent/Spouse Employer:_____

In case of emergency (someone not living with you)

Name:_____Phone Number:_____Relationship:_____

Name:_____Phone Number:_____Relationship:_____

Whom may we thank for referring you?_____

Financial Information:

Who is responsible for this account?_____Relationship:_____

Insurance Company:_____Ins Co. Number:_____Grp#_____

Subscribers Name:_____SSN/ID#_____DOB_____

Relationship to patient:_____ Phone Number:_____

Secondary Insurance: Yes No

Insurance Company:_____Ins Co. Number:_____Grp#_____

Subscribers Name:_____SSN/ID#_____DOB_____

Relationship to patient:_____Phone Number:_____

Dental History

Reason for todays visit:_____

Previous Dentist:_____City:_____State:_____

Date of last dental visit:_____Service provided:_____Last X-Rays:_____

Patient Name:_____ Date:_____

Please check **YES or NO** to indicate if you have had any of the following:

Abnormal Bleeding	yes/no	Glaucoma	yes/no	Scarlet Fever	yes/no
AIDS	yes/no	Headaches	yes/no	Shortness of breath	yes/no
Anemia	yes/no	Heart Murmur	yes/no	Sinus Trouble	yes/no
Arthritis	yes/no	Heart Problems	yes/no	Skin Rash	yes/no
Artificial Heart Valves	yes/no	Hepatitis _____	yes/no	Special Diet	yes/no
Artificial Joints	yes/no	Herpes	yes/no	Stroke	yes/no
Asthma	yes/no	High Blood Pressure	yes/no	Swelling of feet/ankles	yes/no
Back Problems	yes/no	HIV Positive	yes/no	Swollen Neck Glands	yes/no
Blood Disease	yes/no	Jaundice	yes/no	Thyroid Problems	yes/no
Cancer	yes/no	Jaw Pain/TMJ	yes/no	Tonsillitis	yes/no
Chemical Dependency	yes/no	Joint Replacement	yes/no	Tuberculosis	yes/no
Chemotherapy	yes/no	Kidney Disease	yes/no	Tumor or growth on head/neck	yes/no
Circulatory Problems	yes/no	Liver Disease	yes/no	Unexplained Weight loss	yes/no
Congenital Heart Lesions	yes/no	Low Blood Pressure	yes/no	Venereal Disease	yes/no
Mitral Valve Prolapse	yes/no	Ulcers	yes/no	Any Hospital Stay	yes/no
Cortisone Treatment	yes/no	Nervous Problems	yes/no		
Emphysema	yes/no	Pacemaker	yes/no		
Persistent cough	yes/no	Psychiatric Care	yes/no		
Diabetes	yes/no	Radiation Treatment	yes/no		
Epilepsy	yes/no	Respiratory Disease	yes/no		
Fainting or Dizziness	yes/no	Rheumatic Fever	yes/no		

Explain:_____

_____

_____

_____

MEDICATIONS

_____

_____

_____

_____

_____

_____

_____

ALLERGIES

Aspirin Penicillin Codeine

Latex Sulfa drugs Local Anesthetics

Additional:_____

_____

_____

_____

WOMEN:

Are you pregnant yes/no

Due Date:_____

Are you nursing yes/no

Are you on birth control yes/no

X_____

Signature-(if under 18, parent or legal guardian signature)

Kerrville Family Dental

Patient Name:_____DOB:_____

By signing below, I am acknowledging that:

- I am either the patient or the patient's personal representative;
- I have been given the opportunity to receive a copy of the "Notice of Privacy Practices" from Kerrville Family Dental and am also aware on how to access a copy of the Notice.
- I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.
- I have received a copy of the "Kerrville Family Dental Office Policies"

_____

Signature of patient or parent/legal guardian/legally responsible person

_____

Date

_____

Description of relationship to patient