BRUCE SILVA

AUSTIN PREMIER DENTAL

Welcome *We would like to take this time to Welcome you and tell you about our practice. Our patients' health and comfort are very important to us, so we are always learning about new technological advances, materials, and techniques to offer the best quality of care to our patients. Starting today we hope to change your opinion of going to the dentist and create for you a dental experience like you have never had before. Please take your time in filling out all of the requested information. The information that you give us about yourself will help us take even better care of you.*

Personal Information

Name:_______________________________

Address:_______________________________

City:_______________ State:______ Zip:_________

Home Ph:_____________ Cell Ph:_____________

E-Mail Address:_______________________________

Employer:_____________ Work Ph:_____________

What is the best way for us to contact you?_____________

Birthdate:_____________ Social Sec. #:_____________

Driver License:_______________________________

Are you: Single Married Divorced Other

For adults: **Spouse** For children: **Responsible Parent**

Name:_______________________________

Employer:_______________________________

Work Ph:_____________ Cell Ph:_____________

Birthdate:_____________ Social Sec. #:_____________

Do you have any children?_______ How many?_______

Do any of your family members see another dentist?_______

Why?_______________________________

How did you hear about us?_______________________________

If it were one of our awesome patients who referred you, then please let us know. We would like to honor them to show our appreciation and gratitude.

Please list two people for us to contact in case of an emergency:

Name:_______________________________

Phone:_______________________________

Relationship:_______________________________

Name:_______________________________

Phone:_______________________________

Relationship:_______________________________

Financial Information

Who is financially responsible for the account?_______________________________

(If different from the information listed above, please let our Financial Coordinator know. Thank you.)

Payment is due at the time services are rendered. We accept: Cash Checks Debit All Major Credit Cards

How will you be paying for your dental visits?_______________________________

Would you like any information about payment plans that we offer supported by third party financing companies?_______

*There will be possible finance charges for late payments.

Insurance Information

Do you have any dental insurance that you will be using toward your dental visits?_______________

Who is the Policy Holder for the Insurance?_______________________________

Insurance Carrier/Company Name:_______________ Provider/Member Services Ph:_____________

Is the Subscriber/Employee ID different from the Policy Holder's SSN?_______ If so, what is the ID#?_____________

Have you used this Insurance before?_________ If so, when?_______________________________

Medical History

Please answer the following questions adequately and to the best of your knowledge. The more we know about your current medical condition and your past medical history, we will be able to better clinically treat you and avoid any situations that could arise due to a lack of information. Thank you.

Are you currently under a physician's care?_______ Name of Physician:____________________ Phone:________________

If so, why?____

Have you ever been hospitalized or had a major surgery?______________________________________

Have you ever had a serious injury to your head or neck? ______________________________________

Are you currently taking any medications (Prescribed and/or Over-the-Counter)?__________________________

What, if any, medications have you taken in the past?_____________________________________

Allergies

Are you allergic to any of the following:

	Yes	No		Yes	No		Yes	No
Dental Anesthetics	☐	☐	Aspirin	☐	☐	Acrylic	☐	☐
Sulfa	☐	☐	Penicillin	☐	☐	Metal	☐	☐
Iodine	☐	☐	Codeine	☐	☐	Latex Rubber	☐	☐

Do you have any other known allergies?____

Women

Are you pregnant or trying to get pregnant? ____ Are you nursing? ____ Are you taking oral contraceptives? _____

Medical Conditions

Please mark yes or no if you have ever had any of the following conditions. If you currently have any of these conditions, please circle the condition.

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Kidney Problems	☐	☐	Recent Weight Loss	☐	☐
Low Blood Pressure	☐	☐	Renal Dialysis	☐	☐	Arthritis	☐	☐
Blood Disease	☐	☐	7 Disease	☐	☐	Drug Addictions	☐	☐
Anemia	☐	☐	Venereal Disease	☐	☐	Tumors or Growths	☐	☐
Leukemia	☐	☐	AIDS	☐	☐	Heart Disease	☐	☐
Lung Disease	☐	☐	HIV	☐	☐	Irregular Heartbeat	☐	☐
Asthma	☐	☐	Stroke	☐	☐	Heart Murmur	☐	☐
Emphysema	☐	☐	Epilepsy or Seizures	☐	☐	Angina/Chest Pain	☐	☐
Diabetes/ or Hypoglycemia	☐	☐	Glaucoma	☐	☐	Heart Attack	☐	☐
Cancer	☐	☐	Blood Transfusion	☐	☐	Chemotherapy	☐	☐
Congenital Heart Disorders	☐	☐	Bruise Easily	☐	☐	Mitral Valve Prolapse	☐	☐
Stomach/Intestinal Disease	☐	☐	Excessive Bleeding	☐	☐	Rhuematic Fever	☐	☐
Tuberculosis	☐	☐	Swelling of Limbs	☐	☐	Artificial Heart Valve	☐	☐
Liver Disease	☐	☐	Shortness of Breath	☐	☐	Heart Pace Maker	☐	☐
Hepatitis A	☐	☐	Frequent Cough	☐	☐	Heart Surgery	☐	☐
Hepatitis B or C	☐	☐	Sinus Problems	☐	☐	Artificial Joint	☐	☐
Jaundice	☐	☐	Ulcers	☐	☐	Cosmetic Augmentation	☐	☐

Have you ever had, or do you have, any other illness or condition not listed?_______________________________

To my knowledge, the information given above is correct and accurate. I will inform the doctor and staff should any changes occur.

Signature:____ Date:___________________________

Dental History *Everyone has a different opinion about going to the dentist. The most common opinion is not very good; people associate going to the dentist with fear, discomfort, and pain. Our office plans on changing that opinion, we want our patients to know that they are going to be well taken care of and enjoy coming to the dentist. At our office your oral health is our main priority but we will need your assistance. We ask that you answer the following questions truthfully and to the best of your knowledge. Thank you, and we hope you enjoy your visit.*

What is the main reason for today's visit?______________________________

How often do you floss? ☐ Sometimes ☐ All the time ☐ Never Comments:______________

Do your gums ever bleed? ☐ Sometimes ☐ All the time ☐ Never Comments:______________

Do you ever have clicking, popping, or discomfort in the jaw joint? ☐ Sometimes ☐ All the time ☐ Never

If so, which joint, or both?______________________________

Do you use tobacco products? ☐ Sometimes ☐ All the time ☐ Never Comments:______________

Have you ever had braces or any other orthodontic treatment?______ If so, when and for how long?______________

Are any of your teeth sensitive to: ☐ Hot liquids/foods ☐ Cold liquids/foods ☐ Sweet liquids/foods ☐ Chewing Pressure

Comments:______________________________

Do you ever get fever blisters, canker sores, mouth ulcers, or any other oral related lesions?_____ Comments:______________

Do you have Dental Examinations and Cleanings on a routine basis? ☐ No ☐ Yes... ☐ Once a Year ☐ Twice a Year

When was your last: Cleaning:______________ Examination:______________ X-Rays:______________

Please describe what you think your current overall oral health is:______________________________

____

____

Have you ever wanted to change or enhance your smile? If yes, what changes would you make? ______________

____

____

Are you under any stress at this time? If yes, what is causing the stress? ______________

____

____

What did you like, or dislike about your past dentists and dental experiences?______________

____

____

Describe your perfect dentist/dental office:______________________________

____

____

What are the most convenient times for you to arrange dental visits?______________

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