

WELCOME

TO OUR PRACTICE!

Abbeville Dentistry

5255 79th Street
Lubbock, Tx 79424

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

Date _____

PATIENT INFORMATION

Name _____
Last Name First Name Initial

Address _____ Home Phone _____ Cell Phone _____

City _____ State _____ Zip _____ Email Address _____

Sex M F Minor Single Married Divorced Widowed

Soc. Sec. # _____ Birthday _____ DL # _____

Employer _____ Occupation _____ Business Phone _____

How did you here about us? _____

In case of emergency who should we contact? _____

Person responsible for account _____

PRIMARY DENTAL INSURANCE

Insured's Name _____
Last Name First Name Initial

Relationship to Patient _____ Birthday _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Primary Insured Employed By _____ Business Phone _____

Insured Company _____ Phone # _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

ADDITIONAL INSURANCE

Primary Insured Name _____
Last Name First Name Initial

Relationship to Patient _____ Birthday _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Primary Insured Employed By _____ Business Phone _____

Insurance Company _____ Phone # _____

Insurance Company Address _____

Subscriber I. D. # _____ Group # _____

PATIENT INFORMATION

The above information is true and accurate to the best of my knowledge.

Signature _____ Date _____

DENTAL HISTORY

Former Dentist _____

Date of Last X-Rays _____

City, State _____

How Often Do You Floss ? _____

Date of Last Dental Visit _____

How Often Do You Brush ? _____

Please check all that apply:

- Bad Breath.....
- Bleeding Gums.....
- Blisters on Lips or Mouth.....
- Finger Nail Biting.....
- Grinding Teeth.....
- Lip or Cheek Biting.....
- Loose Teeth or Broken Fillings.....
- Orthodontic Treatment.....
- Pain Around Ear.....
- Periodontal Treatment.....
- Sensitivity to Cold.....
- Sensitivity to Heat.....
- Sensitivity to Sweets.....
- Sensitivity When Biting.....
- Frequent Headaches.....
- Jaw, Head or Neck injuries.....
- Jaw Difficultt: Clicking and/or Pain.....
- Tooth Pain.....

MEDICAL HISTORY

Physician's Name _____

Date of Last Visit _____

- | | | | | | |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| | Yes | No | | Yes | No |
| 1. Are you currently under medical treatment..... | <input type="checkbox"/> | <input type="checkbox"/> | 7. Do you wear contact lenses?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever had any serious illnesses or operations?..... | <input type="checkbox"/> | <input type="checkbox"/> | 8. Have you had any allergic reactions to the following | | |
| 3. Are you taking or have you ever taken? | | | Local Anesthetics (eg. novocaine)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Boniva (Bandronate)..... | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin or other Antibiotics..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Fosamax (Alendronate)..... | <input type="checkbox"/> | <input type="checkbox"/> | Sulfa Drugs..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Actonel (Risedronate)..... | <input type="checkbox"/> | <input type="checkbox"/> | Sedatives (sleeping pills)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Aredia (Pamidronate)..... | <input type="checkbox"/> | <input type="checkbox"/> | Barbiturates..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Didronel (Etidronate)..... | <input type="checkbox"/> | <input type="checkbox"/> | Iodine..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Zometa (Zoledronic acid)..... | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you currently taking any medication?..... | <input type="checkbox"/> | <input type="checkbox"/> | Other..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Please List: _____ | | | 9. (Women Only) Are You | | |
| 5. Do you smoke?..... | <input type="checkbox"/> | <input type="checkbox"/> | Pregnant..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you use alcohol, cocaine or other drugs?..... | <input type="checkbox"/> | <input type="checkbox"/> | Nursing..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Taking birth control pills?..... | <input type="checkbox"/> | <input type="checkbox"/> |

Please check all that apply:

- | | | |
|---|---|--|
| Prosthetic Cardiac Valve..... <input type="checkbox"/> | Diabetes..... <input type="checkbox"/> | Nervous Problems..... <input type="checkbox"/> |
| Previous Infective Endocarditis..... <input type="checkbox"/> | Blood Thinners..... <input type="checkbox"/> | Pacemaker..... <input type="checkbox"/> |
| Congenital Heart Disease (CHD)..... <input type="checkbox"/> | Allergy to Latex..... <input type="checkbox"/> | Psychiatric Care..... <input type="checkbox"/> |
| Cardiac Transplantation..... <input type="checkbox"/> | Emphysema..... <input type="checkbox"/> | Radiation Treatment..... <input type="checkbox"/> |
| AIDS..... <input type="checkbox"/> | Epilepsy or Seizures..... <input type="checkbox"/> | Respiratory Disease..... <input type="checkbox"/> |
| Anemia..... <input type="checkbox"/> | Fainting or Dizziness..... <input type="checkbox"/> | Scarlet Fever..... <input type="checkbox"/> |
| Arthritis, Rheumatism..... <input type="checkbox"/> | Glaucoma..... <input type="checkbox"/> | Shortness of Breath..... <input type="checkbox"/> |
| Artificial Joints..... <input type="checkbox"/> | Headaches..... <input type="checkbox"/> | Sinus Trouble..... <input type="checkbox"/> |
| Asthma..... <input type="checkbox"/> | Heart Murmur..... <input type="checkbox"/> | Skin Rash..... <input type="checkbox"/> |
| Back Problems..... <input type="checkbox"/> | Heart Problems..... <input type="checkbox"/> | Stroke..... <input type="checkbox"/> |
| Bleeding abnormally with extractions or surgery..... <input type="checkbox"/> | Hepatitis-Type _____..... <input type="checkbox"/> | Swelling of Feet/Ankles..... <input type="checkbox"/> |
| Blood Disease..... <input type="checkbox"/> | Herpes..... <input type="checkbox"/> | Swollen Neck Glands..... <input type="checkbox"/> |
| Cancer..... <input type="checkbox"/> | High Blood Pressure..... <input type="checkbox"/> | Thyroid Problems..... <input type="checkbox"/> |
| Alcohol or Chemical Dependency..... <input type="checkbox"/> | HIV Positive..... <input type="checkbox"/> | Tonsillitis..... <input type="checkbox"/> |
| Chemotherapy..... <input type="checkbox"/> | Jaundice..... <input type="checkbox"/> | Tuberculosis..... <input type="checkbox"/> |
| Cirulatory Problems..... <input type="checkbox"/> | Jaw Pain..... <input type="checkbox"/> | Tumor or growth on head/neck..... <input type="checkbox"/> |
| Cortisone Treatments..... <input type="checkbox"/> | Kidney Disease..... <input type="checkbox"/> | Ulcer..... <input type="checkbox"/> |
| Cough-persistent or bloody..... <input type="checkbox"/> | Liver Disease..... <input type="checkbox"/> | Venereal Disease..... <input type="checkbox"/> |
| | Low Blood Pressure..... <input type="checkbox"/> | |

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Dr. _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____