horseshoebaydental

New Patient Information

Today's Date:

Name: *Last* *First*

Phone #:

Email:

Mailing Address:

City:

State:

Zip:

Employer:

Phone#:

Height:

Weight:

Date of Birth:

Sex: M F

SS#

Emergency Contact:

Relationship:

Phone #:

If you are completing this form for another person, What is your relationship to that person?

Your Name:

Relationship:

Do You Regularly Keep Up With Your 6-Month Preventative Care Cleaning Appointments? **Y** **N**

Approx Date of Last Dental Cleaning:

Dental Insurance

Name of Subscriber:

DOB:

Insurance Company:

Policy #:

Group #:

Address:

Phone:

We require all insurance information and verification 48 hours prior to your appointment. We file your insurance as a courtesy. If your insurance does not pay within 90 days, Horseshoe Bay Dental reserves the right to full payment. Please note: Your insurance you have is a legal contract between you and your insurance company. Ultimately, you assume responsibility for all charges incurred.

What is most important to you when attending your dental appointment?

Do you have any of the following diseases or problems? (Check UK if you do not know the answer to the question)

	Y	N	UK
Active Tuberculosis	☐	☐	☐
Persistent Cough Greater than 3 Week Duration	☐	☐	☐
Cough that Produces Blood	☐	☐	☐
Been Exposed to Anyone with Tuberculosis	☐	☐	☐

Health History Information

For the following questions, please mark X your responses to the following questions

(Check UK if you do not know the answer to the question)

	Y	N	UK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets, or pressure?	☐	☐	☐
Do you suffer from dry mouth?	☐	☐	☐
Have you had any periodical (gum) treatments?	☐	☐	☐
Have you ever had periodontal (gum) treatments?	☐	☐	☐
Have you ever had any problems associated with previous dental treatments?	☐	☐	☐
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping, or discomfort in the jaw?	☐	☐	☐
Do you grind your teeth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

What is the reason for you dental visit today?

_____

Medical Information

For the following questions, please mark X your responses to the following questions

	Y	N	UK
Are you under the care of a physician?	☐	☐	☐

Physician Name: Phone #:

Address/City/State/Zip:

Date of last physical exam:

	Y	N	UK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, What was the illness or problem?

_____

	Y	N	UK
Are you taking or have you recently taken any prescription or over the counter medicine?	☐	☐	☐
Are you taking blood thinners?	☐	☐	☐

If so, please list all, including vitamins, natural, or herbal preparation and or dietary supplements:

_____

_____

_____

_____

Medical Information

For the following questions, please mark X your responses to the following questions

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? *Circle one:* VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink i n a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
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	☐	☐	☐

	Yes	No	DK
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent Infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

Y	N	DK
☐	☐	☐

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE AND THAT THE INFORMATION GIVEN ON THIS FORM IS ACCURATE. I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY AND THAT MY DENTIST AND THEIR STAFF WILL RELY ON THIS INFORMATION FOR TREATING ME. I ACKNOWLEDGE THAT MY QUESTIONS, IF ANY, ABOUT INQUIRIES SET FORTH ABOVE HAS BEEN ANSWERED TO MY SATISFACTION. I WILL NOT HOLD MY DENTIST, OR ANY OTHER MEMBER OF THEIR STAFF, RESPONSIBLE FOR ANY ACTION THEY TAKE OR DO NOT TAKE BECAUSE OF ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

SIGNATURE OF PATIENT/ LEGAL GUARDIAN: DATE:

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Appointment Cancellation Policy

We pride ourselves in providing extra time for personal attention each patient deserves. We respect your time and make effort to keep you from waiting. As a result, your hour with our hygiene department and several hours with the Doctor is reserved exclusively for you.

It is required that you verbally contact the office 48 hours in advance. Cancellations day of your appointment will receive a fee according to the reason for your visit:

Appointment with Hygiene same day cancellation: $50.00
Appointment with Doctor same day cancellation: $100-$300
No-Show appointment: full appointment fee

After the first "No-Show" without notice, all future appointments will need to be pre-paid. If a patient has 3 last minute cancellations within a 12-month period, we reserve the right to terminate the doctor/patient relationship.

By signing below, I certify that i have read and understand the term and conditions of Horseshoe Bay Dental appointment cancellation policy:

SIGNATURE OF PATIENT/ LEGAL GUARDIAN: DATE:

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HIPPA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been given the opportunity to read a copy of Horseshoe Bay Dental's HIPPA Notice of Privacy Practice.

PRINT OF PATIENTS NAME: DATE:

SIGNATURE OF PATIENT/ LEGAL GUARDIAN:

**HIPPA notice available to read upon request*