Stonebridge Dental

6633 W. Eldorado Pkwy, Ste. 100 | McKinney, TX 75070

PATIENT INFORMATION

Date _____

Name _____ ❑ Married ❑ Single ❑ Minor ❑ Male ❑ Female
Last First M

Address _____
Street Apt # City State Zip

Birth Date _____ Age _____ SS# _____

Telephone _____ Cell _____ Email _____

Place of Employment _____ Phone _____

If Full-time Student, School Name _____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? ❑ Another patient, friend ❑ Another patient, relative

❑ Dental Office ❑ Yellow Pages ❑ Newspaper ❑ School ❑ Work ❑ Other _____

Name of person or office referring you to our practice _____

INSURANCE INFORMATION

Primary

Name of Insured_____ Is insured a patient? ❑ Yes ❑ No

Insured's Birth Date _____ SS# _____ Group # _____

Insured's Address _____
Street Apt # City State Zip

Insured's Employer's Name _____

Address _____
Street City State Zip

Patient's relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insurance Plan Name and Address _____

AUTHORIZATION (All Patients or Guardians must sign)

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits or credit information. I authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

_____ Date _____
Patient's or Guardian's Signature

MEDICAL HISTORY

Are you under a physician's care now? Why? Who? _____ Phone _____ Yes No

Have you ever been hospitalized or had a major operation? Discuss _____ Yes No

Have you ever had a serious injury to your head or neck? Discuss _____ Yes No

Are you taking any medications, pills or drugs? What? _____ Yes No

Are you allergic to any medications or substances? Please check box below

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex Rubber ❑ Other

Women (Please check): ❑ Pregnant/trying to get pregnant ❑ Nursing ❑ Taking oral contraceptives Discuss Yes No

* If yes to any of the starred conditions, please call prior to your appointment...Premedication may be required

	Yes	No
Heart Trouble/Disease	❑	❑
Heart Murmur*	❑	❑
Irregular Heart Beat	❑	❑
Angina/Chest Pain	❑	❑
Heart Attack/Failure	❑	❑
Congenital Heart Disorder	❑	❑
Mitral Valve Prolapse*	❑	❑
Scarlet Fever	❑	❑
Rheumatic Fever*	❑	❑
Artificial Heart Valve*	❑	❑
Heart Pace Maker	❑	❑
Heart Surgery*	❑	❑
High Blood Pressure	❑	❑
Blood Disease	❑	❑
Bruise Easily	❑	❑
Anemia	❑	❑
Excessive Bleeding	❑	❑
Sickle Cell Anemia	❑	❑

	Yes	No
Hemophillia (bleeding problem)	❑	❑
Recent Blood Transfusion	❑	❑
Swelling of Limbs	❑	❑
Lung Disease	❑	❑
Breathing Problem	❑	❑
Shortness of Breath	❑	❑
Frequent Cough	❑	❑
Hay Fever	❑	❑
Sinus Trouble	❑	❑
Asthma	❑	❑
Emphysema	❑	❑
Tuberculosis	❑	❑
Cancer	❑	❑
X-Ray Treatments (Radiation)	❑	❑
Chemotherapy	❑	❑
Stomach/Intestinal Disease	❑	❑
Ulcers	❑	❑
Recent Weight Loss	❑	❑

	Yes	No
Diabetes	❑	❑
Excessive Thirst	❑	❑
Hypoglycemia	❑	❑
Liver Disease	❑	❑
Hepatitis A (Infectious)	❑	❑
Hepatitis B or C	❑	❑
Yellow Jaundice	❑	❑
Kidney Problems	❑	❑
Renal Dialysis	❑	❑
Thyroid Disease	❑	❑
Arthritis/Gout	❑	❑
Rheumatism	❑	❑
Pain in Jaw Joint	❑	❑
Cortisone/Steroid Therapy	❑	❑
Artificial Joint*	❑	❑
Organ Transplant*	❑	❑

	Yes	No
AIDS	❑	❑
HIV Positive	❑	❑
Drug Addiction	❑	❑
Cold Sores	❑	❑
Fever Blisters	❑	❑
Herpes	❑	❑
Stroke	❑	❑
Convulsions	❑	❑
Epilepsy or Seizures	❑	❑
Fainting or Dizziness	❑	❑
Glaucoma	❑	❑
Tumors or Growths	❑	❑
Nervousness	❑	❑
Psychiatric Care	❑	❑
Alzheimer's Disease	❑	❑
Allergies (Pollen/Dust)	❑	❑
Hives or Rash	❑	❑

Have you ever had any illness not checked above? Yes ____ No ____ Discuss _____

Do you smoke? Yes ____ No ____ How many packs / day? _____

Do you use any other form of tobacco? Yes ____ No ____ What kind? _____

Number of sodas or sweet drinks per day? _____

Do you wish to talk to the dentist privately about any problems? Yes ____ No ____ Discuss _____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____

Patient Signature

Reviewed by Doctor _____ Date _____ BP _____

DENTAL HISTORY

Are any family members current patients? Yes No

Name of previous dentist _____

Date of last dental visit _____

How long since last cleaning? _____

Reason for changing _____

Describe your current dental problem _____

_____

APPREHENSION

Do you experience fear of having dental treatment performed? Yes No

Anything specific? _____

Do you dread the numbing after effects? Yes No

Have you had any unpleasant dental experiences? Yes No

Have you ever received laughing gas in a dental office? Yes No

Have you ever received any other kind of sedation for treatment? Yes No

Do you feel you need any help overcoming fear? Yes No

TEETH PROBLEMS

Are your teeth sensitive to hot, cold, sweets or pressure? Yes No

Does food regularly wedge between certain teeth? Yes No

Do you have any areas that are hard to floss? Yes No

YOUR SMILE

Do you think you have a pretty smile? Yes No

Are your teeth crooked? Yes No If so, does this bother you? Yes No

_____

Have you had any cosmetic dentistry? Yes No

Do you have any fillings or blemishes on your teeth that look bad? Yes No

Would you like to have whiter teeth? Yes No

Is there anything that you feel could make your smile look better?

_____

_____

HEADACHES AND FACIAL PAIN

Do you have frequent headaches? Yes No

Do you experience popping or clicking upon opening or closing? Yes No

Do your jaw or facial muscles ever get tired or sore after chewing, sleeping, stress, etc? Yes No

Do you experience facial muscle pain while chewing or when you wake up? Yes No

GUM PROBLEMS

Do your gums ever bleed when you brush or floss: Yes No

Have your gums receded or pulled away from your teeth? Yes No

Do you have bad breath or bad tastes? Yes No