Immediate Smiles
DENTURES & DENTISTRY

20057 Interstate 45 N
Spring, TX 77388

New Patient Forms

Patient Information

Name: _____ Last name: _____ Preferred Name: _____

Ms.___ Mrs.___ Mr.___ DOB: _____ Phone: _____ Gender: M F

Address: _____ City: _____

State: _____ Zip: _____ SSN: _____ Email: _____

Home Phone: _____ How did you hear about us? _____

Emergency Contact Name: _____ Phone: _____

Insurance Information

Insurance name: _____ Insurance Phone #: _____

Primary Subscriber Name: _____ Primary Subscriber SS if different: _____

DOB: _____ Subscriber ID: _____ Group #: _____

Relationship to Subscriber: _____ Employer Name: _____

Authorization

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) healthcare, advice, and treatment to another dentist or for evaluating and administrating any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services that I am responsible for any services to paid or covered by my insurance benefits and any account balance.

Electronics Communications

I consent to receiving HIPPA- compliant electronic communications, such as email and test messages regarding treatment, payment, and healthcare operations. I understand that there is no obligation to receive these electronic communications. Message/date rates may apply and I my opt-out of receiving electronic communications at any time by clicking the unsubscribe link provided in emails or by replying STOP via text. I attest to the accuracy of the information on this page. X_____

MEDICAL HISTORY

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Patient's Printed Name: _____

Although dental professionals primarily treat the area in and around your mouth, your mouth is a part of your entire body of course. Therefore, health problems that you may have, or substances that you may be ingesting are very likely to have an important interrelationship with the dental services you will receive. Thank you for answering the following questions.

Are you under a physician's care now and/or do you have sleep apnea? ❍Yes ❍No If yes, please explain_____

Have you ever been hospitalized or had a major operation? ❍Yes ❍No If yes, please explain _____

Have you ever had a problem with tooth extractions of any kind? ❍Yes ❍No If yes, please explain _____

Have you ever had a serious head/neck injury or head/neck radiation? ❍Yes ❍No If yes, please explain _____

Are you taking any medications, health supplements or controlled substances? ❍Yes ❍No If yes, please explain: _____

Have you ever taken Phen-Fen or Redux (prescribed for weight loss usually)? ❍Yes ❍No If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel, Reclast, Zometa, Prolia or any other medications called bisphosphonates (prescribed for osteoporosis usually)? ❍Yes ❍No If yes, please explain: _____

Have you ever taken blood thinners including but not limited to aspirin, Coumadin or Plavix? ❍Yes ❍No

If yes, please explain: _____

Have you ever taken Selective Serotonin Re-Uptake Inhibitors (SSRIs) for depression or otherwise? ❍Yes ❍No

If yes, please explain: _____

Do you use tobacco in any form (smoking/e-vape, chew, pouches, etc.)? ❍Yes ❍No

If yes, please explain: _____

Do you have diabetes or are you on any special diet of any kind? ❍Yes ❍No

If yes, please explain: _____

Do you currently wear a full or partial denture? If you answered yes, please tell us how old it is. ❍Yes ❍No If yes, please explain: _____

Women: Are you? ❍ Pregnant/Trying to get pregnant ❍ Nursing ❍ Taking oral contraceptives

Are you allergic to any of the following?

❍ Aspirin ❍ Penicillin ❍ Codeine ❍ Acrylic ❍ Metal

❍ Latex ❍ Sulfa Drugs ❍ Local Anesthetics ❍ Other _____

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Do you have, or have you had, any of the following?

AIDS / HIV +	❍Yes ❍No	Cortisone	❍Yes ❍No	Hemophilia	❍Yes ❍No	Radiation Treatment	❍Yes ❍No
Alzheimer's Disease	❍Yes ❍No	Diabetes	❍Yes ❍No	Hepatitis A or B	❍Yes ❍No	Recent Weight Loss	❍Yes ❍No
Anaphylaxis	❍Yes ❍No	Drug Addiction	❍Yes ❍No	Hepatitis C	❍Yes ❍No	Renal Dialysis	❍Yes ❍No
Anemia	❍Yes ❍No	Easily Winded	❍Yes ❍No	Herpes	❍Yes ❍No	Rheumatic Fever	❍Yes ❍No
Angina	❍Yes ❍No	Emphysema	❍Yes ❍No	High Blood Pressure	❍Yes ❍No	Rheumatism	❍Yes ❍No
Arthritis / Gout	❍Yes ❍No	Epilepsy / Seizures	❍Yes ❍No	High Cholesterol	❍Yes ❍No	Scarlet Fever	❍Yes ❍No
Artificial Heart Valve	❍Yes ❍No	Excessive Bleeding	❍Yes ❍No	Hives / Rash	❍Yes ❍No	Shingles	❍Yes ❍No
Artificial Joint	❍Yes ❍No	Excessive Thirst	❍Yes ❍No	Hypoglycemia	❍Yes ❍No	Sickle Cell Disease	❍Yes ❍No
Asthma	❍Yes ❍No	Fainting / Dizziness	❍Yes ❍No	Irregular Heartbeat	❍Yes ❍No	Sinus Trouble	❍Yes ❍No
Blood Disease	❍Yes ❍No	Frequent Cough	❍Yes ❍No	Kidney Problems	❍Yes ❍No	Spina Bifida	❍Yes ❍No
Blood Transfusion	❍Yes ❍No	Frequent Diarrhea	❍Yes ❍No	Leukemia	❍Yes ❍No	Intestinal Disease	❍Yes ❍No
Breathing Problems	❍Yes ❍No	Frequent Headaches	❍Yes ❍No	Liver Disease	❍Yes ❍No	Stroke	❍Yes ❍No
Bruise Easily	❍Yes ❍No	Genital Herpes	❍Yes ❍No	Low Blood Pressure	❍Yes ❍No	Swelling of Limbs	❍Yes ❍No
Cancer	❍Yes ❍No	Glaucoma	❍Yes ❍No	Lung Disease	❍Yes ❍No	Thyroid Disease	❍Yes ❍No
Chemotherapy	❍Yes ❍No	Hay Fever	❍Yes ❍No	Mitral Valve Prolapse	❍Yes ❍No	Tonsilitis	❍Yes ❍No
Chest Pains	❍Yes ❍No	Heart Attack / Failure	❍Yes ❍No	Osteoporosis	❍Yes ❍No	Tuberculosis	❍Yes ❍No
Cold Sores	❍Yes ❍No	Heart Murmur	❍Yes ❍No	Pain in Jaw Joints	❍Yes ❍No	Ulcers	❍Yes ❍No
Cong. Heart Disorder	❍Yes ❍No	Heart Pacemaker	❍Yes ❍No	Parathyroid Disease	❍Yes ❍No	Venereal Disease	❍Yes ❍No
Convulsions	❍Yes ❍No	Heart Disease	❍Yes ❍No	Psychiatric Care	❍Yes ❍No	Yellow Jaundice	❍Yes ❍No

Do you have an illness not listed above? If yes, please explain: _____

To the best of my knowledge, the questions on this form have been answered accurately. I understanding that providing incorrect information may be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Printed Name of Patient, Parent or Guardian

Signature of Patient, Parent or Guardian

_____

Date