*Thank you for visiting Village Endodontics. We want your visit to be pleasant and comfortable. Please help us by completing this form.*

## Patient Information

Name _____
LAST FIRST MIDDLE INITIAL NICKNAME

Address _____
STREET

_____
CITY STATE ZIP

Employer _____ Drivers License _____

Birth date _____ _____ _____

Phone: Home (____) _____ Social Security # _____

Work (____) _____

Mobile (____) _____

Email_____

Emergency: Name _____ Phone (____) _____

## Insurance

**Primary Dental Carrier**

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Ins MAX_____ Met_____ Deductable_____ Met _____

Relation to patient _____

**Insurance Authorization Statement** (Sign & Date)

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I understand it is my responsibility to understand my dental insurance plan and its payment policies. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

**Signature**_____ **Date** _____

## MEDICAL HISTORY

| | | Circle One | |
|---|---|---|---|
| 1. | Have you ever had heart trouble? Describe:..... | Yes | No |
| 2. | Have you ever had rheumatic fever? ..... | Yes | No |
| 3. | Have you ever had a joint replacement? When? ..... | Yes | No |
| 4. | Have you ever been advised to take antibiotics before dental treatment? Why?..... | Yes | No |
| 5. | Have you ever had excessive bleeding after extractions or cuts?..... | Yes | No |
| 6. | Have you ever had hepatitis A, B, C or yellow jaundice? (Circle)..... | Yes | No |
| 7. | Have you ever had a thyroid condition?..... | Yes | No |
| 8. | Have you ever had asthma, hay fever, bronchitis or tuberculosis? (Circle) ..... | Yes | No |
| 9. | Have you ever had high blood pressure?..... | Yes | No |
| 10. | Do you have diabetes?..... | Yes | No |

## Medical History / 2

| | Circle One | |
|---|---|---|
| 11. Have you ever had stomach ulcers? | Yes | No |
| 12. Are you taking any medicines at present? Have you in the past year? Please list: | Yes | No |
| 13. Are you sensitive to any metals or latex? (Circle) | Yes | No |
| 14. Have you ever had a reaction to any drugs or medication? Please list: | Yes | No |
| 15. Have you been under a doctor's care or hospitalized in the past year? Why? | Yes | No |
| 16. Have you ever had a serious illness or condition? | Yes | No |
| 17. Do you have AIDS or HIV? | Yes | No |
| 18. Women: Are you pregnant? | Yes | No |

**DENTAL HISTORY**

| | Circle One | |
|---|---|---|
| 1. Are you having any specific problems with your teeth, gums or mouth? | Yes | No |
| 2. Are your teeth sensitive to hot, cold or sweets? | Yes | No |
| 3. Do your gums bleed after brushing; are they often sore or tender? | Yes | No |
| 4. Do you have difficulty swallowing, chewing or do you frequently chew on one side only? | Yes | No |
| 5. Do you frequently wedge food between your teeth? | Yes | No |
| 6. Have you worn braces for straightening your teeth? | Yes | No |
| 7. In general, do dental treatments cause you much concern or worry? | Yes | No |
| 8. Do you clench or grind your teeth? | Yes | No |
| 9. Do you notice popping, clicking or soreness of the jaws or points just in front of the ears? Which Side? _____ | Yes | No |
| 10 Do you ever have frequent headaches, earaches, stiffness or soreness in your neck? | Yes | No |

**IF THERE IS SOMETHING YOU DO NOT UNDERSTAND, PLEASE ASK US!**

The above information is true to the best of my knowledge. I do hereby authorize: Dr. Brown to administer such anesthetics and perform such dental treatment as may be necessary for the above named person.

Signed _____ Date _____

Signed _____ Phone _____

Relationship to patient: Phone #:

Complaints concerning dental services can be directed to the Texas Board of Dental Examiners at **Phone: (512) 463-6400 or Fax: (512) 463-7452 or by mail at Texas State Board of Dental Examiners 333 Guadalupe, Tower 3, Suite 800 Austin, Texas 78701-3942**.