hallsvillefamilydentistry

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us at

(903) 668-5477

Date _____

Patient Information

Name _____ Birthdate _____ Social Security No. _____
Address _____ City _____ State _____ Zip _____
Sex ☐ Male ☐ Female
Marital Status ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years
Email Address _____ Home Phone (_____)_____
Cell Phone #1 (_____)_____ Cell phone #2 (_____)_____
Employer/School _____ Employer/School Phone (_____)_____
Employer/School Address _____ City _____ State _____ Zip _____
Spouse or Parent's Name _____ Employer _____ Work Phone (_____)_____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone (_____)_____

Responsible Party

Name of Responsible Party_____ Relation to patient _____
Address _____ Home phone (_____)_____
Driver's License # _____ Birthdate _____ Bank _____
Employer _____ Work phone (_____)_____
Currently a patient in our office? ☐ Yes ☐ No Email _____ Cell Phone (_____)_____

Insurance Information

Name of insured _____ Relation to patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Employer _____ Work phone (_____)_____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____
Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max Annual Benefit_____

Additional Insurance

Name of insured _____ Relation to patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Employer _____ Work phone (_____)_____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____
Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max Annual Benefit_____

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Dental History

Reason for today's visit _____ Date of last dental care _____
Former Dentist _____ Date of last dental X-rays _____
Address _____
Check (✓) if you have had problems with any of the following:

☐ Bad breath	☐ Food collection between teeth	☐ Periodontal treatment	☐ Sensitivity to sweets
☐ Bleeding Gums	☐ Grinding Teeth	☐ Sensitivity to cold	☐ Sensitivity when biting
☐ Clicking or popping jaw	☐ Loose teeth or broken fillings	☐ Sensitivity to heat	☐ Sores or growths in mouth

How often do you floss? _____ How often do you brush? _____

Medical History

Physician's name _____ Date of last visit _____
Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine). Pondimin (fenfluramine) and Redux (dexfenfluramine).
☐ Yes ☐ No
Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____
Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____
(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have had problems with any of the following:

☐ Anemia	☐ Chemotherapy	☐ Headaches	☐ Liver Disease	☐ Swelling of Feet or Ankles
☐ Arthritis, Rheumatism	☐ Circulatory Problems	☐ Heart Murmur	☐ Mitral Valve Prolapse	☐ Thyroid Problems
☐ Artificial Heart Valves	☐ Congenital Heart Lesions	☐ Heart problems	☐ Pace Maker	☐ Tobacco Habit
☐ Artificial Joints, Pins, etc.	☐ Cortisone Treatments	☐ Hemophilia	☐ Radiation Treatment	☐ Tonsillitis
☐ Asthma	☐ Cough, Persistent	☐ Hepatitis	☐ Respiratory Disease	☐ Tuberculosis
☐ Back Problems	☐ Cough up blood	☐ Hernia Repair	☐ Rheumatic Fever	☐ Ulcer
☐ Bleeding Abnormally	☐ Diabetes	☐ High Blood Pressure	☐ Scarlet Fever	☐ Venereal Disease
☐ Blood Disease	☐ Epilepsy	☐ HIV/AIDS	☐ Shortness of Breath	
☐ Cancer	☐ Fainting	☐ Jaw Pain	☐ Skin Rash	
☐ Chemical Dependency	☐ Glaucoma	☐ Kidney Disease	☐ Stroke	

List medications you are currently taking and the correlating diagnosis:

_____
_____
_____

Allergies:

_____
_____
_____

Authorization and Release

To the best of my knowledge, the above information is complete and correct, I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s) have insurance coverage with _____
Name of Insurance Company(ies)
and assign directly to Hallsville Family Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentistry may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.