DRS. VAN WART

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Houston, Tx 77005

713-523-1287
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Date:

PATIENT INFORMATION

Name _____ Birthdate __/__/__ Social Security # ___-___-____

Address _____ City _____ State _____ Zip _____

Home Phone (____) ____-____ Cell Phone (____) ____-____ Email

Check Appropriate: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Patient's or Parent's Employer: _____ Work Phone (____) ____-____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone (____) ____-____

If Patient is a Student, Name of School attended _____ City _____ State _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone (____) ____-____

RESPONSIBLE PARTY

Name of Person Responsible For This Account _____ Relation to Patient _____

Driver's Lic # _____ Birthdate __/__/__ Social Security # ___-___-____

Address _____ City _____ State _____ Zip _____

Currently a Patient in our office? ❑ Yes ❑ No Home Phone (____) ____-____

Employer _____ Work 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 _____

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 _____

P A T I E N T I N F O R M A T I O N

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

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 Due date: _____ Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

	Yes	No		Yes	No		Yes	No		Yes	No
Allergies, hay fever sinusitis	☐	☐	Chemotherapy	☐	☐	High blood pressure	☐	☐	Sickle cell anemia	☐	☐
Anemia	☐	☐	Circulatory problems	☐	☐	Any Immune Deficiency	☐	☐	Skin rash	☐	☐
Arthritis, Rheumatism	☐	☐	Cortisone treatments	☐	☐	Jaundice	☐	☐	Slow healing wounds	☐	☐
Artificial heart valves	☐	☐	Cough, persistent or bloody	☐	☐	Kidney disease	☐	☐	Stroke	☐	☐
Artificial joints	☐	☐	Diabetes	☐	☐	Liver disease	☐	☐	Swelling of feet or ankles	☐	☐
Asthma	☐	☐	Emphysema	☐	☐	Low blood pressure	☐	☐	Thyroid problems	☐	☐
Required Hospitalization?	☐	☐	Epilepsy	☐	☐	Mitral valve prolapse	☐	☐	Tonsillitis	☐	☐
Have you used steroids?	☐	☐	Fainting	☐	☐	Pacemaker	☐	☐	Tuberculosis	☐	☐
Date of last episode _____			Glaucoma	☐	☐	Radiation treatment	☐	☐	Tumor or growth on head or neck	☐	☐
Bleeding abnormally with	☐	☐	Headaches	☐	☐	Respiratory disease	☐	☐	Ulcer	☐	☐
extractions or surgery			Heart murmur	☐	☐	Rheumatic fever	☐	☐	Venereal disease	☐	☐
Blood disease, clotting disorders	☐	☐	Heart problems	☐	☐	Scarlet fever	☐	☐	Weight loss, unexplained	☐	☐
Cancer	☐	☐	Hepatitis Type ____	☐	☐	Shortness of breath	☐	☐	Do you wear contact lenses?	☐	☐
Chemical dependency	☐	☐	Herpes	☐	☐	Sinus trouble	☐	☐			

List medications you are currently taking:

_____

Allergy to Penicillin, Aspirin or Other Drugs: Yes ☐ No ☐ Specify: _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental visit _____

Former dentist _____ Date of last dental x-rays _____

	Yes	No		Yes	No		Yes	No
Bad breath	☐	☐	Clench or grind teeth	☐	☐	Orthodontic treatment	☐	☐
Blisters on lips or mouth	☐	☐	Growths or sore spots in your mouth	☐	☐	Nitrous Oxide (laughing gas)	☐	☐
Burning sensation on tongue	☐	☐	Gums swollen, tender or bleeding	☐	☐	Periodontal treatment	☐	☐
Chew on one side of mouth	☐	☐	Jaw pain or tiredness	☐	☐	Sensitivity to pressure or irritants		
Cigarette, pipe or cigar smoking	☐	☐	Lip or cheek biting	☐	☐	(cold, heat or sweets)	☐	☐
Dry mouth	☐	☐	Loose teeth or broken fillings	☐	☐			
Food collection between the teeth	☐	☐	Mouth breathing	☐	☐			

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

Have you ever had an allergic reaction or allergic symptoms to Novocaine, local or general anesthetics? ☐ Yes ☐ No

Have you had trouble from previous dental care? ☐ Yes ☐ No _____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature of patient or parent if minor *Date*

_____ _____

Signature of doctor *Date*