

# DRS. VAN WART

2505 Sunset Blvd.  
Houston, Tx 77005

713-523-1287  
vanwartdental@comcast.net

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	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Circulatory problems	<input type="checkbox"/>	<input type="checkbox"/>	Any Immune Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	Skin rash	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis, Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone treatments	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Slow healing wounds	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valves	<input type="checkbox"/>	<input type="checkbox"/>	Cough, persistent or bloody	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of feet or ankles	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Required Hospitalization?	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Have you used steroids?	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Date of last episode _____			Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatment	<input type="checkbox"/>	<input type="checkbox"/>	Tumor or growth on head or neck	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding abnormally with	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
extractions or surgery			Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease, clotting disorders	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	Weight loss, unexplained	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
Chemical dependency	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>			

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	<input type="checkbox"/>	<input type="checkbox"/>	Clench or grind teeth	<input type="checkbox"/>	<input type="checkbox"/>	Orthodontic treatment	<input type="checkbox"/>	<input type="checkbox"/>
Blisters on lips or mouth	<input type="checkbox"/>	<input type="checkbox"/>	Growths or sore spots in your mouth	<input type="checkbox"/>	<input type="checkbox"/>	Nitrous Oxide (laughing gas)	<input type="checkbox"/>	<input type="checkbox"/>
Burning sensation on tongue	<input type="checkbox"/>	<input type="checkbox"/>	Gums swollen, tender or bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Periodontal treatment	<input type="checkbox"/>	<input type="checkbox"/>
Chew on one side of mouth	<input type="checkbox"/>	<input type="checkbox"/>	Jaw pain or tiredness	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to pressure or irritants (cold, heat or sweets)	<input type="checkbox"/>	<input type="checkbox"/>
Cigarette, pipe or cigar smoking	<input type="checkbox"/>	<input type="checkbox"/>	Lip or cheek biting	<input type="checkbox"/>	<input type="checkbox"/>			
Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	Loose teeth or broken fillings	<input type="checkbox"/>	<input type="checkbox"/>			
Food collection between the teeth	<input type="checkbox"/>	<input type="checkbox"/>	Mouth breathing	<input type="checkbox"/>	<input type="checkbox"/>			

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