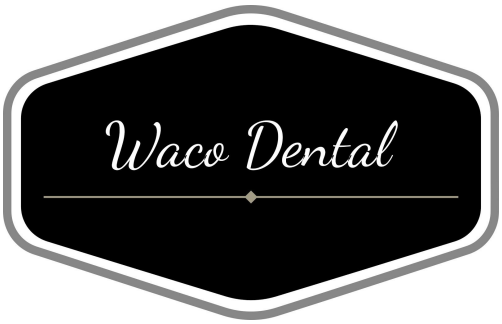

Welcome to Waco Dental, thank you for selecting our dental healthcare team. We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form. If you have any questions or need assistance, please let us know!

PATIENT INFORMATION:

Patient's Name:_____Preferred Name:_____BirthDate:_____
Social Security #:_____Home Phone:_____
Address:_____City:_____ State:_____ Zip:_____
Email:_____Cell Phone:_____Phone Carrier:_____
Circle Appropriate Answer: Minor Single Married Divorced Widowed Separated
Patient or Parent/Guardian's Employer: _____ Work Phone:_____
Spouse or Parent/Guardian's Name:_____Employer:_____
Work Phone:_____
Who May We Thank for Referring you?_____
Person to Contact in Case of Emergency?_____ Phone:_____

RESPONSIBLE PARTY:

Name of Person Responsible for this account:_____Relationship to Patient:_____
Address:_____ City:_____ State:_____ Zip:_____
Home Phone:_____Cell Phone:_____Drive License #:_____
Birth Date:_____Employer:_____Work Phone:_____
Social Security #:_____ Is this person a patient at our office? YES NO
Payment is expected as services are rendered, unless prior financial arrangements have been made.

DENTAL INSURANCE INFORMATION:

Name of Insured:_____Relationship to Patient:_____
Birth Date:_____ Social Security #:_____Employer:_____
Work Phone:_____Address of Employer:_____
City:_____ State:_____Zip Code:_____
Insurance Company:_____Group#:_____Policy ID#:_____
Insurance Company Address:_____Phone #:_____
City:_____State:_____ Zip:_____

PATIENT MEDICAL HISTORY:

Physician:_____Office Number:_____Date of Last Exam:_____

Are you under any medical treatment?-----YES NO
Have you ever been hospitalized for any
Operation or serious illness within the last
5 years?---------- YES NO
If yes, please explain:_____
_____
Are you taking any medication(s) including
non-prescription?----------YES NO
If yes, what medication(s) are you taking?_____
_____
Do you use tobacco?----------YES NO
Do you use controlled substances?-------YES NO
Are you wearing contact lenses:----------YES NO

Are you allergic to or have had any
reactions to the following?
Local Anesthetics----------YES NO
Penicillin OR other Antibiotics--YES NO
Sulfa Drugs----------YES NO
Barbiturates, Sedatives, or Sleeping
Pills----------YES NO
Iodine----------YES NO
Aspirin----------YES NO
Latex Materials----------YES NO
Codeine or other narcotics------YES NO
Other:_____

Do you have any of the following?

- ❏ Abnormal bleeding after extractions, surgeries, or trauma
- ❏ AIDS or HIV positive
- ❏ Allergies or Hives
- ❏ Alcoholism
- ❏ Anemia or blood disorder
- ❏ Artificial Joints, valve or stint
- ❏ Arthritis
- ❏ Asthma
- ❏ Blood Transfusion
- ❏ Cancer or Tumor
- ❏ COPD
- ❏ Depression/Anxiety
- ❏ Diabetes
- ❏ Epilepsy, seizures, or fainting spells
- ❏ Hay Fever or sinus trouble
- ❏ Heart Ailment or angina
- ❏ Heart Murmur, mitral valve prolapse, heart defect
- ❏ Hepatitis or other liver disease
- ❏ Herpes or Cold sores
- ❏ High or low blood pressure
- ❏ Hypoglycemia
- ❏ Kidney Disease
- ❏ Migraine Headaches or frequent headaches
- ❏ Pacemaker
- ❏ Stomach Problems
- ❏ Stroke
- ❏ Tuberculosis or other lung problems
- ❏ Trigeminal Neuralgia
- ❏ Thyroid Problems

WOMEN:

- ❏ May be pregnant Expected delivery date:_____
- ❏ Taking hormones or contraceptives

Do you have any disease, condition, or problem not listed above?_____
Signature of Patient (or parent):_____Date:_____