KILLEEN DENTAL

DEVIN GNEITING, DMD - DAVI WILLIAMS, DMD

PATIENT INFORMATION *(Please Print Clearly)*

Name of Patient _____ SS# _____

Address _____Apt. #_____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone/Other_____

Date of Birth _____ Age _____ Sex _____ Race _____ Marital Status _____

E-Mail Address _____ Employer _____ Position _____

HOW DID YOU HEAR ABOUT OUR OFFICE? Check all that apply:

_____Google Search _____ Facebook _____ Yelp _____ Website _____ Doctor/Insurance _____ Office location

_____Friend/Existing Patient (Name:_____) _____Other_____
(Please Specify)

Parent or Responsible Party (if patient is under age 18)

Mother/Guardian's Name _____

Date of Birth _____Marital Status_____

Social Security No. _____

Address _____ Apt. # _____

City _____State _____ Zip _____

Home No. _____Cell No. _____

Employer _____ Work No. _____

E-Mail Address _____

Will the above party be responsible for any balance on the account? YES NO (circle one)

Father/Guardian's Name _____

Date of Birth _____ Marital Status_____

Social Security No. _____

Address _____ Apt. # _____

City _____ State _____ Zip _____

Home No. _____Cell No. _____

Employer _____ Work No. _____

E-Mail Address _____

Will the above party be responsible for any balance on the account? YES NO (circle one)

Emergency Contact: _____ Phone No. _____

Relationship to Patient? _____

If the patient is covered by any dental insurance, please fill out the following:

Insurance Name _____ Insurance Phone No. _____
Employer _____ Phone No. _____ Group No. _____
Subscriber's Name _____ Subscriber's Date of Birth _____
Subscriber's SSN or ID # _____ Relationship to Patient _____
Rank (If Military) _____ Military Branch _____
Sponsor's Unit (If Military) _____ Unit Phone Number _____

If the patient is covered by a second insurance, please fill out the following:

Insurance Name _____ Insurance Phone No. _____
Employer _____ Phone No. _____ Group No. _____
Subscriber's Name _____ Subscriber's Date of Birth _____
Subscriber's SSN or ID # _____ Relationship to Patient _____
Rank (If Military) _____ Military Branch _____
Sponsor's Unit (If Military) _____ Unit Phone Number _____

CONSENT FOR SERVICES

I understand that forms for insurance claims will be submitted as long as I provide all the information necessary to complete filing. I authorize release of any information concerning the health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to the dentist. Staff will calculate ESTIMATED deductible and co-pay. Payment of this amount is due the day services are rendered. I understand that I am responsible for all costs of dental treatment within 30 days.

Patient or Legal Guardian's Signature: _____ Date: _____

HEALTH HISTORY FORM

As required by law (HIPAA), our office adheres to written policies and procedures to protect the privacy of information about you that we create receive or maintain. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name _____ Height _____ Weight _____ Date of Birth ____/____/_____ Sex ☐M ☐F
Last First Middle

Reason for today's visit?_____

Medical Information

ALLERGIES

Are you allergic to or have you had a reaction to any of the following? To all "Yes" responses specify type of reaction.

☐ Latex ☐ Local anesthetics ☐ Aspirin ☐ Penicillin ☐ Codeine or other narcotics

☐ Metals ☐ Sulfa Drugs ☐ Foods ☐ Hay fever/seasonal ☐ Barbiturates, sedatives, or sleeping pills

☐ Any other allergies _____ ☐ No Known Allergies

If yes to any, please explain reaction: _____

WOMEN ONLY

Yes	No	Don't Know	
☐	☐	☐	Are you pregnant? If yes, how many weeks? _____ Due Date: _____
☐	☐	☐	Taking birth control pills or hormonal replacement? _____ Nursing? _____

CONGENITAL HEART DISEASE / ARTIFICIAL JOINTS

Yes	No	Don't Know	
☐	☐	☐	Artificial (prosthetic) heart valve
☐	☐	☐	Previous infective endocarditis
☐	☐	☐	Damaged valves in transplanted heart

Yes	No	Don't Know	
☐	☐	☐	Congenital heart disease (CHD)
☐	☐	☐	Unrepaired, cyanotic CHD
☐	☐	☐	Repaired (completely) in last 6 months
☐	☐	☐	Repaired CHD with residual defects

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

☐	☐	☐	Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If so, when was this operation done? _____
☐	☐	☐	Have you had any complications or difficulties with your prosthetic joint? If yes, specify _____
☐	☐	☐	**Has a physician or other dentist recommended you take antibiotics prior to dental treatment?**

Yes	No	Don't Know	
☐	☐	☐	Are you taking or have taken oral bisphosphonates? (Fosamax, Actonel, Boniva) or I.V. Bisphosphonates? (Actonel or Aredia) If so, for how long? _____
☐	☐	☐	Are you now under the care of a physician? If so, what is/are the condition(s) being treated? _____
			_____ Date last seen by this physician _____
			Physician(s) _____ Name Phone Address City/State/Zip
☐	☐	☐	Are you taking or have you recently taken any medicine(s) including non-prescription medicine? If so, what are you taking? Prescribed _____
			Over the Counter/Herbal remedies _____
☐	☐	☐	Do you use tobacco (smoking, snuff)? If so, how interested are you in stopping? (Check one) ☐Very ☐Somewhat ☐Not Interested

Yes	No	Don't Know	
☐	☐	☐	Abnormal bleeding
☐	☐	☐	AIDS or HIV infection
☐	☐	☐	Anemia
☐	☐	☐	Hemophilia
☐	☐	☐	Arthritis
☐	☐	☐	Rheumatoid arthritis
☐	☐	☐	Systemic lupus erythematosus
☐	☐	☐	Autoimmune disease
☐	☐	☐	Cancer / chemotherapy / radiation treatment
☐	☐	☐	Cardiovascular disease

If yes, specify below:
- ❍ Angina
- ❍ Arteriosclerosis
- ❍ Congestive Heart Failure
- ❍ Damaged heart valves
- ❍ Heart attack Date: _____
- ❍ Heart murmur
- ❍ High blood pressure
- ❍ Low Blood Pressure
- ❍ Mitral valve prolapse
- ❍ Pacemaker
- ❍ Rheumatic Fever
- ❍ Rheumatic heart disease
- ❍ Stroke Date: _____

Yes	No	Don't Know	
☐	☐	☐	Chronic pain
☐	☐	☐	Chest pain upon exertion
☐	☐	☐	Eating disorder

If yes, specify _____

☐	☐	☐	Gastric reflux
☐	☐	☐	Gastrointestinal disease
☐	☐	☐	Ulcers
☐	☐	☐	Diabetes. If yes, specify:

- ❍ Type I (Insulin dependent)
- ❍ Type II

☐	☐	☐	Epilepsy
☐	☐	☐	Fainting spells or seizures
☐	☐	☐	Glaucoma
☐	☐	☐	Hepatitis, jaundice or liver disease
☐	☐	☐	Kidney Problems
☐	☐	☐	Mental health disorders

If yes, specify _____

☐	☐	☐	Migraines / severe headaches
☐	☐	☐	Night Sweats
☐	☐	☐	Neurological disorders

- ❍ Post Traumatic Syndrome (PTSD)
- ❍ Traumatic Brain Injury (TB
- ❍ Other _____

Yes	No	Don't Know	
☐	☐	☐	Osteoporosis
☐	☐	☐	Persistent swollen glands in neck
☐	☐	☐	Respiratory problems.

If yes, specify below:
- ❍ COPD
- ❍ Emphysema
- ❍ Bronchitis, etc.
- ❍ Asthma
- ❍ Tuberculosis

☐	☐	☐	Severe or rapid weight loss
☐	☐	☐	Sexually transmitted disease

If yes, specify _____

☐	☐	☐	Sinus trouble
☐	☐	☐	Sleep disorder
☐	☐	☐	Thyroid problems
☐	☐	☐	Do you have any disease, condition or problem not listed above that you think I should know about? Please explain:

_____

_____

Dental Information

Date of your last dental exam _____ Date of last dental x-rays _____

What was done at that time? _____

How do you feel about the appearance of your teeth?_____

NOTE: Both doctor and patient is encouraged to discuss any and all relevant patient health issues prior to treatment.
I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

I authorize the taking of radiographs, study models, photographs, or other diagnostic aids deemed appropriate to aid in the diagnosis of my dental health.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf (if any).

_____ _____

Signature of Patient/Legal Guardian Date Relationship to Patient

For Completion by Dentist / Auxiliary

Comments:

_____

Signature of Dentist / Auxiliary _____ Date _____