Welcome To Friendswood Dental Group

Patient Information

Have you been a patient of our practice? ◯ Yes ◉ No If Yes, When?

Title First Name Middle Initial Last Name

Preferred Name Age Sex

Date of Birth Maritial Status Social Security Number

Home Mailing Address Apt #

City State TX Zip code

Home Phone Work Phone Cell Phone

Student Status Name of School

Employment Status Employer

Occupation

Work Address Suite

City State TX Zip Code

Responsible Party or Spouse Information

Relationship Type If 'Other' is selected, what is the relationship?

Title First Name Middle Initial Last Name

Social Security Number

Home Mailing Address Apt #

City State TX Zip code

Home Phone Work Phone Cell Phone

Employment Status Employer

Occupation

Work Address Suite

City State TX Zip Code

Referral Information

Referred by Referral Name or source

Name of Previous Dentist Phone

Name of Medical Doctor Phone

Name of Medical Specialist i.e. Cardiologist Phone

Emergency Information - A Person not living with you

Name Relationship Phone

Address City State TX Zip Code

I understand that the responsibility for payment for services provided by this office for myself or my dependents is mine and is due and payable at the time services are rendered. Accounts are not to exceed 6 months. The policy of this office is the parent or guardian who accompanies a child and requests treatment for a child is responsible for the services rendered.

Signature of patient or Responsible Party Current Date

Insurance Information

Primary Insurance

Dental Coverage ○ Yes ◉ No

Medical Coverage ○ Yes ◉ No

Orthodontic Coverage ○ Yes ◉ No

Insurance Company Name

Phone Number

Group/Plan/Local/Policy Number

Insurance Company Address (Street/PO Box)

City State TX Zip Code

Insured's Name

Insured's Social Security Number Subscriber ID

Insured's Birthdate Relation to Patient

Insured's Employer

Employer's Address

City State TX Zip Code

Medical Questionnaire

1). Have you been a patient in a hospital in the past two years? If so, for what were you hospitalized?

○ Yes ◉ No

2). Are you now, or have you been under the care of a physician (including a psychiatrist) during the past two years? If so, for what were you treated?

○ Yes ◉ No

3). List medicines or drugs you have taken during the past year and for what.

Medication	For What?

4). Have you taken cortisone or other hormone medications? If so, please list.

○ Yes ◉ No

5). Have you had any surgical procedures in the past? Describe surgery and name of surgeon.

○ Yes ◉ No

6). Have you had a reaction to any medicine? Example: penicillin, sulfa, codeine, Vicoden? List and describe.

○ Yes ◉ No

7). Do you have any fever or any allergies? If so, describe.

○ Yes ◉ No

8). When you cut yourself or have a tooth extracted, do you bleed so much that you have to see a doctor to have it stopped?

○ Yes ◉ No

9). Have you ever had a reaction during, or following dental treatment or oral surgery?

○ Yes ◉ No

10). Do you faint easily?

○ Yes ◉ No

11). Have you gained or lost more than 15 pounds recently?

○ Yes ◉ No

12). Do you use tobacco products? ○ Yes ◉ No Type _____ How Much? _____

13). Do you have any sores or growths in your mouth?

○ Yes ◉ No

14). Have you ever had any serious injuries to your face or jaws? Describe:

○ Yes ◉ No

15). Do you have any disease, condition or problem not listed above that you think we should know about?

○ Yes ◉ No

16). Have you had a blood transfusion within the last 7 years?

- ○ Yes
- ◉ No

17). Women: **ARE YOU PREGNANT?**

- ○ Yes
- ◉ No

18). Select the name of any of the following, which you have had:

- ☐ Stroke
- ☐ Heart Problems
- ☐ Heart attack
- ☐ Chest pain angina
- ☐ Irregular heart beat
- ☐ Congenital heart disease
- ☐ Replacement of heart valve
- ☐ Heart murmur
- ☐ MVP (Mitral Valve Prolapse)
- ☐ Congestive heart failure
- ☐ High blood pressure
- ☐ Arthritis
- ☐ Blood disease
- ☐ Rheumatic fever
- ☐ Anemia
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Hepatitis (Yellow Jaundice)
- ☐ Kidney or Bladder trouble
- ☐ Thyroid disease
- ☐ HIV/AIDS/Autoimmune Disease
- ☐ Syphilis or Venereal Disease
- ☐ Diabetes
- ☐ Seizures (Epilepsy)
- ☐ Cancer
- ☐ X-ray therapy for Cancer
- ☐ Chemotherapy for Cancer
- ☐ Ulcers
- ☐ Nervous disorders
- ☐ Alcohol abuse
- ☐ Drug abuse including marijuana

19). Are you taking or have you ever taken any of the following medications?
These medicines are used for osteoporosis and cancer chemotherapy treatment.

- ☐ Boniva - (Ibandronate sodium)
- ☐ Fosamax - (Aldendronate)
- ☐ Didrocal - (Etidronate)
- ☐ Didronel - (Etidronate)
- ☐ Actonel - (Rosedronate)
- ☐ Aredia - (Disodium Pamidronate)
- ☐ Bondronat - (Ibandronic Acid)
- ☐ Bonefos - (Sodium Clodronate)
- ☐ Loron - (Sodium Clodronate)
- ☐ Zometa - (Zoledronic Acid)

20). Additional remarks

Signature of Patient or Responsible Party

Current Date

Dental Questionnaire

I. Chief Complaint

How may we help you?

General Dental

Do you have any uncomfortable or painful teeth?

Do you have any broken or rough teeth?

Do you have any missing teeth? ◯ Yes ◉ No

Do you have any replacement teeth? ◯ Yes ◉ No

II. TMJ Disfunction

How is your bite?

Have you ever worn braces or been told you need them? ◯ Yes ◉ No

Are you able to chew well and comfortably? ◯ Yes ◉ No

Does your jaw ever pop, click or hurt you? ◯ Yes ◉ No

Do you have any harmful oral habits? If yes, then explain.

III. Periodontal

Have you ever been treated for gum disease? ◯ Yes ◉ No

Do your gums bleed or bother you now? ◯ Yes ◉ No

Do you ever have bad breath or a bad taste in your mouth? ◯ Yes ◉ No

Has any of your family lost teeth due to gum disease? ◯ Yes ◉ No

IV. Esthetics

How do you feel about the appearance of your mouth?

What would you change about your mouth if you could?

Do you ever feel that your teeth could be lighter? ◯ Yes ◉ No

V. General Background

How is your (spouse's) dental health?

Have your dentists always taken good care of you?

Have you had any bad experience in a dental office? ◯ Yes ◉ No

How is your general health?

Friendswood Dental Group

Carmac D. Taylor Jr. D.D.S.

#2 Oaktree Friendswood, Texas 77546 281.482.2631

Patient _____ **Current Date** _____

A. *Notice of Privacy Practices Acknowledgement*

I, _____ , acknowledge that I have been given a copy of Friendswood Dental Group's Notice of Privacy Practices.

Printed name of patient or patient representative

Signature of patient or patient's representative _____

Relationship to patient (if other than patient) _____

B. *Patient Consent for use and Disclosure of Protected Health Information*

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you; however, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

* Protected health information may be disclosed or used for treatment, payment or health care operations
* The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
* The Practice reserves the right to change the Notice of Privacy Policies
* The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
* The patient may revoke this Consent in writing at any time and all future disclosures will then cease
* The Practice may condition treatment upon the execution of this Consent.

Consent was signed by _____

Printed name of patient or patient representative

Signature of Patient or Patient's representative _____

Relationship to Patient _____

Restrictions _____

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Friendswood Dental Group Permission for Photography

Patient Current Date

I give my permission for Friendswood Dental Group to photograph my procedure including pre-operative and post-operative photographs for clinical educational purposes.

Friendswood Dental Group uses photography to document procedures for educational programs, training, public relations, and marketing.

1. I give my permission for photographs to be taken during my procedure.

Initial Here

2. I give my permission for photographs of my procedure to be used for Educational purposes.

Initial Here

3. I give my permission for photographs of my procedure to be used for marketing purposes and on marketing materials owned by Friendswood Dental Group.

Initial Here

4. Names and/or personal information will not be released with photographs.

Initial Here

Signature of Patient or Patient's representative

Relationship to patient

Please print a copy of the form for your records and "Submit by Email" if you have e-mail software.

Print Form Submit by Email