DENTAL GALLERY
WACO

PATIENT HISTORY INFORMATION

Name: ____
(first name) (middle name) (last name)

Sex: ____ M ____ F **Date of Birth:** _____/_____/_______ **Social Security Number:** ______ – ______ – ___________

Street Address: ____

City: ______________________________ **State:** ______ **Zip:** ________ **E-Mail:** ______________________________

Home Phone: ______________________ **Work Phone:** ______________________ **Cell Phone:** ______________________

Emergency Contact Name: ______________________________ **Emergency Contact Phone:** ________________________

Race: ____ African American ____ Asian American ____ Caucasian/White ____ Hispanic ____ Other

Name of Family Physician: ______________________________ **City:** ____________________ **State:** ______

What is your reason for today's visit? ____

1) Have you received treatment in our office previously? ❑ YES ❑ NO If yes, when? ________________________

2) What specific communication led you to choose The Dental Gallery Today? (check one)

❑ Magazine ❑ Newspaper ❑ Radio ❑ Billboards/Sign ❑ Brochure/Mail ❑ Television

❑ Yellow Pages ❑ Friend/Relative ❑ Internet/Web Site ❑ Other Doctor ❑ Outside Agency

Do you have commercial dental insurance? ❑ Yes ❑ No

Name of insurance: ____

Speak with our front desk regarding options to utilize your insurance benefits.

Are you a current CareCredit cardholder? ❑ Yes ❑ No

Speak with our front desk regarding options to utilize cardholder benefits.

Are you currently wearing dentures? ❑ Yes ❑ No

Any previous tooth extractions? ❑ YES ❑ NO If yes, when? ________________________

Have you taken, are you taking, or are you scheduled to begin taking medications for osteoporosis

❑ Oral Bisphosphonates: (Alendronate (Fosamax, Fosamax Plus D) • Etidronate (Didronel)
Ibandronate (Bonicva) • Risedronate (Actonel) • Tiludronate (Skelid))?

❑ Intravenous Bisphosphonates: (Clodronate (Bonefos) • Pamidronate (Aredia) or
Zoledronic Acid (Reclast, Zometa))?

❑ Prolia (Denosumab)?

Do you use or have you used tobacco products?

(Circle Past or Currently per relevant mark)

- ❑ Smoking (Past/Currently)
- ❑ Snuff (Past/Currently)
- ❑ Chew (Past/Currently)
- ❑ Bidis (Past/Currently)
- ❑ Vaping (Past/Currently)

Do you drink alcoholic beverages?

❑ YES ❑ NO ❑ DK

Are you alcohol dependent?

❑ YES ❑ NO ❑ DK

Do you use or have you used prescription or street drugs or other substances for recreational purposes?

(Circle Past or Currently per relevant mark)

- ❑ Cocaine (Past/Currently)
- ❑ Ecstasy (Past/Currently)
- ❑ Heroin (Past/Currently)
- ❑ Marijuana (Past/Currently)
- ❑ Methamphetamine (Past/Currently)
- ❑ Oxycontin (Past/Currently)
- ❑ Other: (Past/Currently)

Are you drug dependent?

❑ YES ❑ NO ❑ DK

FEMALES ONLY

Are you pregnant?

❑ YES ❑ NO ❑ DK

If yes, how many weeks? ______

Are you nursing?

❑ YES ❑ NO ❑ DK

Are you taking birth control pills, fertility drugs or hormonal replacement?

- ❑ Birth Control
- ❑ Fertility Drugs
- ❑ Hormonal Replacement

Allergies: Are you allergic to or have you had a reaction to any of the following?

- ❑ Local anesthetics (Novocaine, Lidocaine)
- ❑ Penicillin
- ❑ Sulfa drugs
- ❑ Aspirin
- ❑ Codeine or other narcotics
- ❑ Hay fever/Seasonal (allergic rhinititis)
- ❑ Metals/jewelry (nickel, chrome)
- ❑ Iodine
- ❑ Latex (rubber)
- ❑ Food/other: ______________________

Specify type of reaction:

____

❑ **No Allergies**

Medications

Are you taking, have you recently (within the last month) taken, or are you supposed to be taking any medications (prescription, over the counter, diet supplements, vitamins, natural or herbal)? ❑ YES ❑ NO ❑ DK

If yes, specify medication(s), dosage and frequency: ____

Medications Prescription / Over Counter	**Dosage / Frequency**	**Supplements** Diet Supplements, Vitamins (natural or herbal)	**Dosage / Frequency**

Do you take blood thinners daily (including Aspirin): ❑ YES ❑ NO ❑ DK

If yes, circle: Coumadin • Xarelto • Plavix • Other: ______________________

Medical Conditions – Check any/all that apply

Heart/Blood Pressure Problem:
(Check any that apply)

- ☐ Rheumatic fever / Rheumatic heart disease
- ☐ Infective endocarditis
- ☐ Artificial heart valves
- ☐ Congenital heart defect
- ☐ Heart murmur
- ☐ Mitral valve prolapse
- ☐ Angina (chest pain)
- ☐ Heart attack ____date most recent____
- ☐ Heart failure
- ☐ Coronary heart disease
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Palpitations
- ☐ Arrhythmia (irregular heart beat
- ☐ Shortness of breath
- ☐ Swelling of the ankles
- ☐ Pacemaker
- ☐ Implantable defibrillator
- ☐ Other: _______________

Respiratory / Lung Problem

- ☐ Asthma
- ☐ Emphysema / COPD
- ☐ Tuberculosis
- ☐ Sinusitis
- ☐ Bronchitis
- ☐ Persistent cough
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Other: _______________

Cancer or Tumors

- ☐ Malignant
  Location: _______________
- ☐ Benign
  Location: _______________

Kidney / Urinary Disorder

- ☐ Renal failure/insufficiency
- ☐ Dialysis
- ☐ Frequent urination
- ☐ Other: _______________

Diabetes / Endocrine Disorder

- ☐ Diabetes
  - Type 1
  - Type 2
- ☐ Thyroid problems
  - Hypothyroidism
  - Hyperthyroidism
- ☐ Other: _______________

Neurologic / Nerve Problem

- ☐ Stroke ____date most recent____
- ☐ TIA (Transient Ischemic Attack)
- ☐ Seizures/Epilepsy
- ☐ Multiple sclerosis
- ☐ Parkinson's disease
- ☐ Neuropathies
- ☐ Dementia/Alzheimer's (memory loss)
- ☐ Headaches
- ☐ Fainting or dizzy spells
- ☐ Feeling of tingling or numbness
- ☐ Psychiatric disease/ Mental health disorder
- ☐ Bipolar/Manic depression
- ☐ Schizophrenia
- ☐ Depression
- ☐ ADD/ADHD (attention deficit disorder)
- ☐ Feelings of anxiety
- ☐ Feelings of depression
- ☐ Other: _______________

Blood / Hematologic Disorder

- Anemia
- Sickle cell disease
- Sickle cell trait
- Bruise easily
- Leukemia
- Lymphoma
- Bleeding disorders
- Hemophilia
- Other: _______________

Stomach / Intestine / Liver Disorder

- Cirrhosis/Chronic hepatitis
- Jaundice (skin/eyes turn yellow)
- Hepatitis: A B C D
  Other: ______ Circle One
- Heartburn
- Acid reflux (GERDS)
- Ulcers
- Crohn's disease
- Other: _______________

Muscle / Bone / Connective Tissue Disorder

- Joint replacement
- Arthritis
  - Rheumatoid
  - Osteoarthritis
  - Other: _______________
- Osteoporosis
- Gout
- Temporomandibular Joint disorder
- Lupus
- Fibromyalgia
- Other: _______________

Infectious Disease

- HIV
- AIDs
- STD (sexually transmitted disease)
  - Syphilis
  - Gonorrhea
  - Chlamydia
  - Genital herpes
  - Human papillomavirus
- Cold sores
- Other: _______________

Head / Eyes / Ear / Nose / Throat Problem

- Vision problems
- Glaucoma
- Hearing impairment
- Other: _______________

Dermatologic / Skin Problem

Specify: ________________

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Dermatologic / Skin Problem

- Bulimia
- Anorexia
- Other: _______________

Do you have any other problem, not listed above?

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For Office Use: **Is a Medical Consult Necessary:** ☐ YES ☐ NO

For Office Use: **Height:** _______________ **Weight:** _______________ **BMI:** _______________

Patient Signature: ____ Date: ______/______/________

Our Payment Policy
We gladly accept payment by cash, MasterCard, Visa, American Express, Discover, and checks with proper identification.