patient information

patient name _____ social security # _____-_____-_____
last first middle initial

address: _____ DOB: ____/____/_____

city: _____ state: _____ zip: _____ age: _____

email: _____ Sex: ☐ M ☐ F

marital status: _____

phone #'s: home: _____-_____-_____ work: _____-_____-_____ ext _____ cell: _____-_____-_____

occupation: _____ employer/school: _____ employer phone: _____-_____-_____

dentistry: how can we help you

Who can we thank for referring you? _____

What had you switch dentists? _____

Do you have any dental fear or anxiety? ☐ yes ☐ no

if yes, please explain: _____

Are you proud of your smile? ☐ yes ☐ no

is there anything that you would like to improve? _____

What is the most important aspect(s) of your dentist?

☐ gentle ☐ cost ☐ accurate price ☐ same day treatment ☐ warrantied work

☐ other _____

dental insurance

who is responsible for this patient financially? _____

insurance company: _____ group # _____ Employer _____
subscriber's employer

subscriber: _____ subscriber social security number: _____-_____-_____ subsc. DOB ___/___/___
if not above if not above

how is the patient related to the subscriber? _____

assignment and release

I certify that I, and/or my dependent(s) have insurance coverage with the above named insurance company and assign directly to Dr Tye Thompson and/or Permian Basin Dental Center LP all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr Ballew or his office staff may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when written documentation is given to the office.

_____ _____ ____/____/_____
print name signature of patient, parent/guardian date

dental history

reason for todays vist: _____

date of last dental visit (approx): ____/____/_____ date of last dental x-rays ____/____/_____

place a checkmark for any of the following that apply:

- ☐ bad breath
- ☐ bleeding gums
- ☐ blisters on lips or mouth
- ☐ burning sensation on tongue
- ☐ use of tobacco
- ☐ cheek biting
- ☐ dry mouth
- ☐ fingernail biting
- ☐ food collection
- ☐ foreign objects
- ☐ grinding teeth
- ☐ swollen gums (or tender)
- ☐ loose teeth
- ☐ mouth pain
- ☐ orthodontic tx
- ☐ jaw pain/clicking/tiredness
- ☐ periodontal tx
- ☐ sores
- ☐ sensitivity to: ☐ cold ☐ hot ☐ sweets ☐ biting/pressure

how often do you brush? _____ how often do you floss? _____

for office use only:

dr.'s considerations: _____

medical history

** have you ever taken any of the group of drugs collectively referred to as "fen-fen"? (phentermine, pondimin, fenfluramine, redux, dexfenfluramine) yes no

place a checkmark for any of the following that apply:

- ☐ AIDS/HIV
- ☐ hepititus Type___
- ☐ artificial heart Valve
- ☐ artificial Joints
- ☐ asthma
- ☐ special diet
- ☐ blood disease
- ☐ cancer
- ☐ high blood pressure
- ☐ chemotherapy
- ☐ tumor (head/neck)
- ☐ pacemaker
- ☐ psychiatric care
- ☐ emphysema
- ☐ epilepsy
- ☐ anemia
- ☐ glaucoma
- ☐ heart Murmer
- ☐ heart Problems
- ☐ herpes
- ☐ jaundice
- ☐ jaw pain
- ☐ tonsilitis
- ☐ liver disease
- ☐ cortisone tx
- ☐ venereal disease
- ☐ diabetes
- ☐ radiation tx
- ☐ respiratory Disease
- ☐ fainting or dizziness
- ☐ arthritis/rheumatism
- ☐ Sinus Trouble
- ☐ skin rash
- ☐ stroke
- ☐ swollen feet/ankles
- ☐ swollen neck glands
- ☐ circulatory problems
- ☐ kidney disease
- ☐ nervous problems
- ☐ mitral valve prolapse
- ☐ weight loss (unexplained)
- ☐ bisphosphonates (bone density medications)
- ☐ rheumatic Fever
- ☐ scarlet Fever
- ☐ headaches
- ☐ shortness of breath
- ☐ back problems
- ☐ abnormal bleeding with extractions or surgery
- ☐ thyroid problems
- ☐ chemical dependency
- ☐ tuberculosis
- ☐ low blood pressure
- ☐ congenital heart lesions
- ☐ cough (persistent/bloody)

women:

- ☐ pregnant
- ☐ taking birth control
- ☐ nursing

if any marked, please breifly explain _____

_____

allergies:
- ☐ asprin
- ☐ local anesthetic
- ☐ penicillin
- ☐ codeine
- ☐ sulfa
- ☐ iodine
- ☐ latex
- ☐ barbiturates (sleeping pills)
- ☐ other _____

* Current medications: _____

_____

for office use only:

dr.'s considerations: _____

signature _____