DIAZ
DENTAL STUDIO

8355 Walnut Hill Lane, Suite 240 • Dallas, Texas 75231
214.691.2323 • www.diazdentalstudio.com

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial ____

Home Address _____ City _____ State _____ Zip _____

Home Phone # (_____)_____ Work Phone # (_____)_____

Cell Phone # (_____)_____ Email _____

Employer _____ Date of Birth _____ Social Security # _____

Name of Spouse _____ Spouse's Birth date _____

Spouse's Employer _____ Spouse's Social Security # _____

Name of Dental Insurance _____ Group Plan Number _____

Person Financially Responsible _____ Relationship _____

Billing Address _____

Name to call in case of emergency _____ Phone # (_____)_____

Whom may we thank for referring you _____

Former Dentist _____

Physician's Name _____ Phone # (_____)_____

Are you on a special or prescribed diet? ❑ yes ❑ no If yes, please explain: _____

How many soft drinks do you have per day? _____ coffee/tea _____ sugar? _____

If you smoke, how many cigarettes/cigars/pipes per day? _____

Have you ever used nitrous dental gas? ❑ yes ❑ no Do you want to use it for dental work? ❑ yes ❑ no

How long since your last dental visit? _____ What was done? _____

Why did you decide to change dentist? _____

Have you had an unfavorable dental visit? _____

Have you lost any of your natural teeth? ❑ yes ❑ no If yes, how? _____

Have they been replaced? ❑ yes ❑ no

Are you happy with the appearance of your teeth? ❑ yes ❑ no If not, why? _____

Name of Physician _____

Most recent Physical _____

Current weight _____ height _____

List any medications, herbal supplements, and/or vitamins taken with-in the last two years: _____

_____

_____

_____

_____

Please describe any current medical treatment, impending surgery, or other treatment that may affect your dental treatment: _____

_____

_____

_____

_____

Have you noticed in your mouth any of the following (check all that apply):

- ❑ Mouth sores that do not heal?
- ❑ Cold sores on lips?
- ❑ Growth, swelling, sore spots?Pain
- ❑ or tenderness in your teeth?
- ❑ Bleeding gums?
- ❑ Food catching between the teeth?
- ❑ Bad breath?
- ❑ Teeth that feel loose?

Have you had or been aware of any of the following (check all that apply):

- ❑ Tired feeling in your face while chewing?
- ❑ Ringing or pain in your ear?
- ❑ Pain around your ears, eyes, head or
- ❑ neck?Clenching and/or grinding teeth?
- ❑ Headaches?
- ❑ Difficulty in swallowing?

Please select an answer for each of the following:
Are you allergic to any of the following?

Yes	No	
❑	❑	Aspirin
❑	❑	Ibuprofen (Advil)
❑	❑	Acetaminophen (Tylenol)
❑	❑	Penicillin/Amoxicillin/Ampicillin
❑	❑	Erythromycin
❑	❑	Tetracycline
❑	❑	Codeine
❑	❑	Local Anesthetics
❑	❑	Fluoride
❑	❑	Metals (gold, stainless steel, _____)
❑	❑	Latex
❑	❑	Any other medication _____
❑	❑	Are you required to take antibiotic pre-medication before dental treatment? If yes, for what condition _____

Please select an answer for each of the following:
Do you have any of the following conditions?

Yes	No	
❑	❑	Heart problems (surgery, disease, attack)
❑	❑	Congenital Heart Disease
❑	❑	Heart murmur
❑	❑	Rheumatic fever
❑	❑	High blood pressure
❑	❑	Low blood pressure
❑	❑	History of a stroke
❑	❑	Artificial prosthesis (heart valve or joints)
❑	❑	Pacemaker
❑	❑	Anemia
❑	❑	Prolonged bleeding due to slight cut
❑	❑	Emphysema
❑	❑	Tuberculosis
❑	❑	Asthma
❑	❑	Sinus problems
❑	❑	Kidney disease
❑	❑	Liver disease
❑	❑	Jaundice
❑	❑	Thyroid or parathyroid disease
❑	❑	Arthritis
❑	❑	Diabetes (❑ Insulin ❑ Diet controlled)
❑	❑	Stomach ulcers
❑	❑	Digestive disorders
❑	❑	Glaucoma
❑	❑	Epilepsy or convulsions (seizures)
❑	❑	Hepatitis (type _____)
❑	❑	HIV/AIDS
❑	❑	Radiation therapy (head or neck)
❑	❑	Chemotherapy
❑	❑	Tumor or abnormal growth
❑	❑	Any lumps or swelling in the mouth
❑	❑	Hives, skin rash, hay fever
❑	❑	Alcohol or drug dependency
❑	❑	Emotional problems
❑	❑	Psychiatric treatment
❑	❑	Antidepressant medications
❑	❑	Fainting/dizziness
❑	❑	Are you presently being treated for any illness _____
❑	❑	Aware of changes in your general health
❑	❑	Steroid/Cortisone in the last 2 years
❑	❑	Often exhausted or fatigued
❑	❑	Subject to frequent headache
❑	❑	Head or neck injuries
❑	❑	Any disease/condition not listed _____ _____

I certify that I have read and understand the above and will not hold my dentist or his staff responsible for any errors or omissions in completion of this form.

Signature: _____ Date: _____

Permission is given to perform necessary dental work on myself/for my child.