Lubbock Family Dental

8220 Memphis Avenue Lubbock, TX 79423 806.745.1745
www.LubbockFamilyDental.com

Patient Information

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

❑ Male ❑ Female ❑ Married ❑ Single ❑ Child

Birth Date: _____ SS#: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____

_____ (City) _____ (State) _____ (Zip)

Referred by: _____

Employment Information

The following is for: ❑ Patient ❑ The person responsible for payment

Employer Name: _____ Phone: _____

Address: _____

_____ (City) _____ (State) _____ (Zip)

Spouse or Responsible Party Information

The following is for: ❑ Patient's Spouse ❑ The person responsible for payment

Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

❑ Male ❑ Female ❑ Married ❑ Single ❑ Child

Birth Date: _____ SS#: _____ Driver's License#: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____

_____ (City) _____ (State) _____ (Zip)

EMERGENCY CONTACT

Name _____ Relationship _____

Telephone _____

Primary Dental Insurance Information

Name of Insured: _____ _____ _____
Last First MI

Insured's Birth Date: _____ ID#: _____ Group#: _____

Insured's Address: _____

_____ _____ _____
City State Zip

Insured's Employer Name: _____

Employer Address: _____

_____ _____ _____
City State Zip

Patient's relationship to insured: ❑ Self ❑ Spouse ❑ Child

Insurance Plan Name: _____

Insurance Address: _____

_____ _____ _____
City State Zip

Are you covered by two Dental Insurance Policies? ❑ Yes ❑ No

Medical Information

Please indicate if you have any of the following:

❑ Year of most recent medical checkup? _____
❑ Primary Care Physician? _____
❑ Heart Trouble or Disease? When? _____
❑ Heart Surgery? Pacemaker?
❑ Heart Murmur?
❑ Stroke?
❑ Abnormal Blood Pressure?
❑ Blood Thinners? Daily Aspirin?
❑ Cancer? Chemo and or Radiation Therapy?
❑ Diabetes? Type _____
❑ Hepatitis? Type _____
❑ Stomach Problems?
❑ Breathing Problems? Asthma? Tuberculosis?
❑ Autoimmune Disease? Fibromyalgia, Lupus, etc.
❑ Do you have HIV/AIDS?
❑ Kidney Disease? Bladder Problems?
❑ Hospitalized? When/Where _____
❑ Surgery in the last 5 years?
❑ Implants? Joint, Knee, Breast, Other
❑ Allergy to any medications? _____
❑ Reaction to an injection or anesthetic?
❑ Do you take Sedatives or Tranquilizers?
❑ Osteoporosis? Medication:
❑ Bisphosphonate therapy (Fosamax, Boniva etc.)?
❑ Women: Are you pregnant or possibly pregnant?
❑ ANY OTHER MEDICAL CONDITION?

DENTAL HISTORY

❑ Dental checkup or treatment during the last year?
❑ Periodontitis? (gum disease)
❑ Take antibiotics before dental treatment?
❑ Tobacco use of any form?

List all medication you take: _____

_____

Date: _____

_____
Signature