

Texas Implant & Dental Center - Fort Worth

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Fort Worth, TX 76107

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Patient Personal Information					
Title	Preferred Name	Birth Date	Age		
Last, First		Marital Status	Sex		
Address		Home #	Work #		
		Cell #	Drive Lic		
City, State, Zip		Emergency Contact	Emergency Phone #		
Email		Student	SSN		
Health Care Guardian Name		School Name			
Health Care Guardian Phone #		Referral Type			

Person responsible/guarantor for paying bills					
Title	Preferred Name	Birth Date	Age		
Last, First		Marital Status	Sex		
Address		Home #	Work #		
		Cell #	Drive Lic		
City, State, Zip		SSN			
Email					

Do you have Primary Dental Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			Do you have Secondary Dental Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Group No/Name			Group No/Name		
Insurance Name			Insurance Name		
Phone #			Phone #		
Employer Name			Employer Name		
Subscriber Last, First			Subscriber Last, First		
Subscriber Address			Subscriber Address		
City, State, Zip			City, State, Zip		
Relationship to Patient	Birth Date		Relationship to Patient	Birth Date	
Subscriber ID			Subscriber ID		

Patient Medical Information					
ALLERGIES		<input type="checkbox"/> Y <input type="checkbox"/> N No Change Since Last Recorded	<input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N Addisons	
<input type="checkbox"/> Y <input type="checkbox"/> N No Known Allergies	<input type="checkbox"/> Y <input type="checkbox"/> N No Known Concerns or Issues		<input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells/Dizziness	<input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Infection	
<input type="checkbox"/> Y <input type="checkbox"/> N Aspirin			<input type="checkbox"/> Y <input type="checkbox"/> N Leg Pain	<input type="checkbox"/> Y <input type="checkbox"/> N Autoimmune Disease	
<input type="checkbox"/> Y <input type="checkbox"/> N Barbiturates / Sleeping Pills	Blood, Heart and Circulation	<input type="checkbox"/> Y <input type="checkbox"/> N Paralysis	<input type="checkbox"/> Y <input type="checkbox"/> N Parkinson's Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Cancer	
<input type="checkbox"/> Y <input type="checkbox"/> N Codeine	<input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Problems	<input type="checkbox"/> Y <input type="checkbox"/> N Severe Headaches or Migraines	<input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy	
<input type="checkbox"/> Y <input type="checkbox"/> N Clindamycin	<input type="checkbox"/> Y <input type="checkbox"/> N Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N Neuromuscular Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Spinal Cord Stimulator	<input type="checkbox"/> Y <input type="checkbox"/> N Growths or Tumors	
<input type="checkbox"/> Y <input type="checkbox"/> N Darvon	<input type="checkbox"/> Y <input type="checkbox"/> N Angina	<input type="checkbox"/> Y <input type="checkbox"/> N Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis	
<input type="checkbox"/> Y <input type="checkbox"/> N Demerol	<input type="checkbox"/> Y <input type="checkbox"/> N Ankles Swell	<input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion		<input type="checkbox"/> Y <input type="checkbox"/> N Leukemia	
<input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin	<input type="checkbox"/> Y <input type="checkbox"/> N Arteriosclerosis	<input type="checkbox"/> Y <input type="checkbox"/> N Bruise Easily		<input type="checkbox"/> Y <input type="checkbox"/> N Lupus	
<input type="checkbox"/> Y <input type="checkbox"/> N Food Allergies	<input type="checkbox"/> Y <input type="checkbox"/> N Artificial Heart Valve	<input type="checkbox"/> Y <input type="checkbox"/> N Cardiovascular Disease	Ear, Nose and Throat	<input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment	
<input type="checkbox"/> Y <input type="checkbox"/> N Hay Fever / Seasonal Allergies	<input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion	<input type="checkbox"/> Y <input type="checkbox"/> N Chest Pain Upon Exertion	<input type="checkbox"/> Y <input type="checkbox"/> N Cochlear Implant	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever	
<input type="checkbox"/> Y <input type="checkbox"/> N Iodine	<input type="checkbox"/> Y <input type="checkbox"/> N Bruise Easily	<input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect	<input type="checkbox"/> Y <input type="checkbox"/> N Persistent Cough	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatism	
<input type="checkbox"/> Y <input type="checkbox"/> N Latex Rubber	<input type="checkbox"/> Y <input type="checkbox"/> N Cardiovascular Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Damaged Heart Valve	<input type="checkbox"/> Y <input type="checkbox"/> N Sinus Trouble	Kidneys and Urinary	
<input type="checkbox"/> Y <input type="checkbox"/> N Local Anesthetics	<input type="checkbox"/> Y <input type="checkbox"/> N Artificial Heart Valve		Endocrine System	<input type="checkbox"/> Y <input type="checkbox"/> N Excessive Urination	
<input type="checkbox"/> Y <input type="checkbox"/> N Metals	<input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion		<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes Type I	<input type="checkbox"/> Y <input type="checkbox"/> N Dialysis/Kidney Failure	
<input type="checkbox"/> Y <input type="checkbox"/> N Nitrous Oxide	<input type="checkbox"/> Y <input type="checkbox"/> N Bruise Easily			<input type="checkbox"/> Y <input type="checkbox"/> N Kidney Disease	
	<input type="checkbox"/> Y <input type="checkbox"/> N Cardiovascular Disease			<input type="checkbox"/> Y <input type="checkbox"/> N Kidney Transplant	

- Y N NSAIDs
- Y N Percodan
- Y N Penicillin
- Y N Pet Allergies
- Y N Sulfa Drugs
- Y N Tetracycline
- Y N Valium
- Y N Vicodin
- Y N Other Environmental
- Y N Other Medications

Allergic Reaction(s)

- Y N None
- Y N Anaphylaxis
- Y N Difficulty Breathing
- Y N Dizziness or Light-Headed
- Y N Itching
- Y N Nausea or Vomiting
- Y N Skin Rash or Hives
- Y N Swelling

Past Medical History:

Please check all that apply

- Y N Heart Attack
- Y N Heart Failure
- Y N Heart Murmur
- Y N Heart Stent (last 6 months)
- Y N Heart Surgery/Bypass
- Y N Hypertension
- Y N Low Blood Pressure
- Y N Implanted Defibrillator
- Y N Mitral Valve Prolapse
- Y N Pacemaker/LVAD
- Y N Phlebitis or Blood Clots
- Y N Rheumatic Heart Disease

Bones, Joints and Muscles

- Y N Artificial Joints
- Y N Arthritis
- Y N Chronic Pain
- Y N Fibromyalgia
- Y N Osteoarthritis
- Y N Osteoporosis

Brain and Nerves

- Y N Aneurysm
- Y N Convulsions

- Y N Diabetes Type II
- Y N Excessive Thirst
- Y N Graves
- Y N Hyperthyroid
- Y N Hypothyroid

Eyes and Vision

- Y N Eye Disease
- Y N Cataracts
- Y N Glaucoma
- Y N Macular Degeneration

Digestive System

- Y N Eating Disorders
- Y N Gastrointestinal Disease
- Y N GE Reflux Disease (GERD)
- Y N Liver Disease
- Y N Persistent Diarrhea
- Y N Stomach Problems
- Y N Stomach Ulcers
- Y N Unusual Weight Loss

Immune System

- Y N Implanted Bladder
- Y N Jaundice

Mouth and Teeth

- Y N Clicking of the Jaw Joint
- Y N Fever Blisters
- Y N Frequently Dry Mouth
- Y N Locking of the Jaw

Lungs and Breathing Topics

- Y N Asthma
- Y N Bronchitis
- Y N Emphysema
- Y N COPD
- Y N Oxygen at Home
- Y N Pneumonia (last 2 months)
- Y N Pulmonary Hypertension
- Y N Shortness of Breath
- Y N Tuberculosis

Additional Comments

Dental Questionnaire

Insurance Information

Do you have Primary Dental Insurance _____

Insurance Name _____

Group No/Name _____

Employer Name _____

Subscriber Last, First Name _____

Relationship to Patient _____

Birthdate _____

Subscriber ID _____

Dental Questionnaire

What prompted you to schedule a visit? Please check all that apply _____

Other (please specify) _____

Date of last dental visit or consultation? _____

Reason for visit? _____

Were any of the following mentioned during that visit? check all that apply _____

Name of previous Dentist	_____
Phone	_____
Have you had any head, neck or jaw injuries ?	_____
Do you notice popping, clicking or soreness of the jaws or points just in front of the ears ?	_____
Do you have difficulty in opening your mouth widely ?	_____
Do you wear dentures or partials ?	_____
If Yes, how long have you been wearing them?	_____
Have you ever been told you need to pre-medicate for a dental visit?	_____
If yes, which antibiotic were you prescribed?	_____
Have you ever had any complications following dental treatment?	_____
If yes, please explain	_____
Additional Comments	
Any Disease, Condition or Problem not Listed ? Please list	_____

Medical Questionnaire

Medical Insurance

Medical Insurance Carrier	_____
Address	_____
City / State / Zip	_____
Medical Insurance Carrier Phone	_____
Medical Insurance Carrier Employer Name	_____
Medical Insurance Carrier Subscriber Name	_____
Medical Insurance Carrier Subscriber ID #	_____
Medical Insurance Carrier Subscriber Birthdate	_____

Physician Information

Are you currently under active care of a Physician ?	_____
If Yes, what is the condition being treated ?	_____
Date of last Medical Exam?	_____
Primary Care Physician's Name	_____
Primary Care Physician's Phone Number	_____
Cardiologist's Name (If Applicable)	_____
Cardiologist's Phone Number (If Applicable)	_____
Neurologist's Name (If Applicable)	_____
Neurologist's Phone Number (If Applicable)	_____
Oncologist's Name (If Applicable)	_____
Oncologist's Phone Number (If Applicable)	_____

Pulmonologist's Name (If Applicable)

Pulmonologist's Phone Number (If Applicable)

Health History

What Pharmacy do you regularly use? Name and Address (or main cross-streets)

Have you had any serious illness, operation or been hospitalized within the past 2 years ?

If Yes, what illness or problem ?

Have you ever had Cancer?

If yes, please tell us more about your status.

Are you Diabetic or Pre-Diabetic?

If yes, what is your A1c level?

Do you have Heart Disease?

If yes, please list the specifics of your Heart Disease.

Do you have a Medical Clearance from your Cardiologist?

Other (please specify)

Social History

Tobacco Use, select all that apply

How often?

Alcohol Use

Marijuana Use

Other illicit drugs

How often?

General Anesthesia

Have you or a blood relative ever had problems with general or local anesthesia and/or iv sedation?

Have you ever been told you had a difficult intubation (placement of breathing tube)?

History of motion sickness/nausea/vomiting after surgery?

Are you sensitive to pain medication or sleeping pills?

Are you being treated for a chronic pain condition?

Difficulty walking? Do you use:

Have you ever taken: please check all that apply

Alendronate (Fosamax®)

Bevacizumab (Avastin®)

Denosumab (Prolia®)

Denosumab (XGEVA®)

Fenfluramine/Phentermine (Fen-Phen)

Ibandronate (Boniva®)

Pamidronate (Aredia®)	<input type="checkbox"/>
Risedronate (Actonel®)	<input type="checkbox"/>
Sorafenib (Nexavar®)	<input type="checkbox"/>
Sunitnib (Sutent®)	<input type="checkbox"/>
Zolendronate (Reclast®)	<input type="checkbox"/>
Zolendronate (Zometa®)	<input type="checkbox"/>
GLP-1 Analogs (Ozempic, Mounjaro, Wegovy, etc.)	_____
How Long	_____
Last Dose	_____

Please list any medications you are currently taking and their dosage:

1: Medication, Dosage, Instructions (Type NONE if not taking any medications)	_____
2: Medication, Dosage, Instructions	_____
3: Medication, Dosage, Instructions	_____
4: Medication, Dosage, Instructions	_____
5: Medication, Dosage, Instructions	_____
6: Medication, Dosage, Instructions	_____
7: Medication, Dosage, Instructions	_____
8: Medication, Dosage, Instructions	_____
9: Medication, Dosage, Instructions	_____
10: Medication, Dosage, Instructions	_____
11: Medication, Dosage, Instructions	_____
12: Medication, Dosage, Instructions	_____

Women Only

Are you pregnant?	_____
If Yes, how many months?	_____
OB/GYN's Name	_____
OB/GYN's Phone Number	_____
Are you currently nursing ?	_____
Are you on birth control pills / fertility drugs ?	_____

Additional Comments

Any Disease, Condition or Problem not Listed ? Please list	_____
Do you wish to speak with the doctor privately about anything?	_____

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Signature

Date

Dentist Signature

Date