Welcome Lake Texoma Dental Care & Wellness

Patient Name:_____ What Do You Prefer To Be Called? _____
LAST FIRST M

Birthdate: _____ Age:_____ ❑Male ❑Female

Mailing Address: _____
ADDRESS CITY STATE ZIP

S.S.N:_____

HomePhone#:(_____)_____ E-Mail Address: _____

Work Phone #: (_____) _____ For Appointment Reminders: Call Email Text
(circle which one, or ones, you prefer)

Cell Phone#: (_____) _____

Employer: _____ Occupation: _____

Status: ❑Minor ❑Single ❑Married ❑Divorced ❑Separated ❑Widowed Drivers License#:_____

Spouse's Name: _____ Do you have Children? ❑Yes ❑No How Many? _____

In Case of Emergency. Who do we call?_____ _____ _____ _____
PHONE# RELATION

Person Responsible for Your Dental Investment

Name: _____ Home Phone: (____)_____

Relation: _____ Work Phone: (____)_____

Primary Dental Insurance

Insurance Co. Name: _____ Insured's ID#: _____

Phone #: (____)_____ Group # _____

Insured's Name: _____ Relation: _____ Date of Birth: _____

Insured's Employer:_____

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
Initials

We Would Like To Get To Know You Better

Name: _____ **Date:** _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Date of last Dental exam: _____

Are you under a physician's care now? Yes No If yes, Specify: _____

Have you ever been hospitalized or had a major operation? Yes No If yes, Specify: _____

Have you ever had a serious head or neck injury? Yes No If yes, Specify: _____

Are you taking any medications, pills, or drugs? Yes No If yes, Specify: _____

Do you use tobacco? Yes No If yes, Specify: _____

Do you use controlled substances? Yes No If yes, Specify: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

❑Aspirin ❑Penicillin ❑Codeine ❑Local Anesthetics ❑Acrylic ❑Metal ❑Latex ❑ Sulfa Drugs

❑Other If yes, explain: _____

Do you have, or have you had, any of the following:

Aids/HIV Positive	❑Yes ❑No	Chemotherapy	❑Yes ❑No	Kidney Problems	❑Yes ❑No
Artificial Heart Valve	❑Yes ❑No	Diabetes	❑Yes ❑No	Pace Maker	❑Yes ❑No
Artificial Joint	❑Yes ❑No	Epilepsy or Seizures	❑Yes ❑No	If Yes, When Was It Installed?	
Asthma	❑Yes ❑No	Heart Disease	❑Yes ❑No	_____	
Blood Thinner	❑Yes ❑No	Hepatitis A	❑Yes ❑No	Stroke	❑Yes ❑No
Cancer	❑Yes ❑No	Hepatitis B or C	❑Yes ❑No	Thyroid Disease	❑Yes ❑No
If Yes, What Type?		High Blood Pressure	❑Yes ❑No		
_____					

Have you ever had any serious illness not listed above? ❑Yes ❑No

If yes, please explain:_____

Are you required to Pre-Medicate with antibiotics before dental treatment ❑Yes ❑No

Do you consume grapefruit juice, grapefruits or grapefruit extract? ❑Yes ❑No

Why did you leave your last dentist? _____ What is your present problem? _____

We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

- Our policy requires payment in full, at the time services are rendered, unless other arrangements have been made. If account is not paid within 45 days of the date of service and no financial arrangements have been made, you will be responsible for collection agency fees, interest charges and any other expenses incurred in collection of your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information, and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.
- I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you.

Print Name_____ **Signature** _____ **Date**_____

❑Adult Patient ❑Parent or Guardian ❑Spouse

Doctor *Dr. Stephen McAnaney D.D.S.* **Doctor Signature** _____ **Date**_____