

**Deal Family Dental**  
**Complete Family & Cosmetic Dentistry**

**Patient Information**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First MI (Preferred Name)

Address: \_\_\_\_\_  
Street City/State Zip code

Sex (M or F) \_\_\_\_\_ Marital Status: \_\_\_\_\_ Birth Date \_\_\_\_\_

Phone (Home) \_\_\_\_\_ Phone (Work) \_\_\_\_\_ Cell# \_\_\_\_\_

Email Address \_\_\_\_\_ Social Security # \_\_\_\_\_

**Are any other immediate family members patients here? \_\_\_\_ If so, who? \_\_\_\_\_**

**Insurance Information**

Subscriber Name \_\_\_\_\_ SS# \_\_\_\_\_ Birth Date \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_ Phone \_\_\_\_\_

Mailing Address \_\_\_\_\_ Effective Date \_\_\_\_\_

Employer Name \_\_\_\_\_ Employer Phone \_\_\_\_\_

**Responsible Party**

Person responsible for the account \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_  
Street City/State/Zip Code Phone #

Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

**Health Information**

**Do you have any of the following conditions? Please check those that apply:**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Allergies         | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> HIV Positive/AIDS     | <input type="checkbox"/> Pregnancy                    |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Penicillin Allergy           |
| <input type="checkbox"/> Taking Aspirin    | <input type="checkbox"/> Heart Attack        | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Respiratory Problems         |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Mental Disorders      | <input type="checkbox"/> Rheumatic Fever              |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Sinus Problems               |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Nervous Disorders     | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pace Maker            | <input type="checkbox"/> Tuberculosis                 |

**Do you have any conditions or illnesses not listed above? \_\_\_\_\_ If so, please list them below.**

\_\_\_\_\_

**Are you currently taking any over-the-counter or prescription medications? \_\_\_\_\_ If so, please list them.** \_\_\_\_\_

**Circle any of the following medications you may be allergic to:**

- |              |            |              |           |           |        |
|--------------|------------|--------------|-----------|-----------|--------|
| Aspirin      | Darvocet   | Valium       | Novocaine | Xylocaine | Darvon |
| Erythromycin | Penicillin | Tetracycline | Percodan  | Codeine   |        |

**If any, what other medications are you allergic to? \_\_\_\_\_**

## Referral Information

How were you referred to our practice? Another patient, Name: \_\_\_\_\_ Billboard: \_\_\_\_\_  
A Dental Office, Name: \_\_\_\_\_ A Physician's office, Name: \_\_\_\_\_  
Log Cabin Newspaper \_\_\_\_\_ Downey Yellow Pages \_\_\_\_\_ Alltel Yellow Pages \_\_\_\_\_ SBC Yellow Pages \_\_\_\_\_  
Greers Ferry Yellow Pages \_\_\_\_\_ Drive-By \_\_\_\_\_ Website \_\_\_\_\_ Other \_\_\_\_\_

## Personal Information

Briefly tell us about yourself. \_\_\_\_\_  
\_\_\_\_\_

Do you have any hobbies? If so, tell us about them. \_\_\_\_\_  
\_\_\_\_\_

Have you ever had a bad experience at the dentist? \_\_\_\_\_

When was your last dental visit? \_\_\_\_\_ What is the reason for this visit? \_\_\_\_\_

Previous dentist's name and address: \_\_\_\_\_

Why did you leave your previous dentist? \_\_\_\_\_

When were X rays last taken of your teeth? \_\_\_\_\_

How frequently do you brush your teeth? \_\_\_\_\_ Soft or Hard bristle toothbrush? \_\_\_\_\_

**Do you have concerns regarding your teeth?** \_\_\_\_\_  
\_\_\_\_\_

Yes No Have you lost any of your teeth?

Yes No Do you clench or grind your teeth?

Yes No Do you have tooth or jaw discomfort?

Yes No Do you have frequent headaches?

Yes No Do you have a click or pop in your jaw joint?

Yes No Are your teeth sensitive to hot or cold?

Yes No Are any teeth uncomfortable when biting down?

Yes No Would you like information on tooth whitening?

Yes No Do your gums bleed when you brush or floss?

Yes No Are you interested in aesthetic treatments to improve your smile?

Yes No Would you like information on six month braces to improve your smile?

Are there any conditions or concerns about your health that we need to discuss that have not been covered in this questionnaire? \_\_\_\_\_  
\_\_\_\_\_

I hereby authorize Drs. Stephen & Rachel Deal and staff to take X-rays, photographs, or any other diagnostic aids needed to diagnose my dental needs. I also authorize the release of any information, including the diagnosis and records of any treatments, X-rays, photographs, or examinations rendered to my insurance company, or to another medical office needing my medical or dental history. I authorize Drs. Deal to perform dental procedures on me, my minor children and/or elderly family members. I will inform Drs. Deal of any changes in my health.

Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_