

KLEIN DENTAL CENTER
JAMES W. NEAL, DDS, FAGD
16832 Stuebner Airline
Spring, Texas 77379-6207
281-376-3600

*Welcome to Klein Dental Center. Please take a few moments to fill out the following information as completely as possible:
(Please Print with Ink)*

Patient's Name (last) _____ (first) _____ (middle initial) _____

Home Address _____ Apt# _____ City _____ State _____

Zip _____ Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Sex: M () F () Social Security No. _____

Driver's License No. _____ Email Address _____

Employer _____ Street Address _____

City _____ State _____ Zip Code _____

In Case of Emergency: Name and phone number of next closest relative to patient:

Name _____ Phone Number _____

If patient is not responsible for payment of this account please complete the following information:

Responsible Person's Name (last) _____ (first) _____ (middle initial) _____

Home Address _____ Apt# _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Social Security No. _____

Drivers License No. _____ Relationship to Patient _____

Employer _____ Street Address _____

City _____ State _____ Zip _____

Responsible person's Email address _____

How did you hear about our office? _____

If you were referred by someone, whom may we thank for the referral? _____

PLEASE CHECK EACH BOX, INDIVIDUALLY, DO NOT DRAW LINE THROUGH

MEDICAL HISTORY

Physician _____ Office Phone _____ Date of Last Exam _____

- Yes No**
1. Has a physician ever advised you to take pre-medication prior to dental care?.....() ()
2. Have you ever been hospitalized for any surgical Operation or serious illness within the past 5 years?..... () ()
If yes, please explain _____
3. Are you taking any medications including OTC non-Prescription or herbal supplements..... () ()
If yes, what meds are you taking? _____
4. Have you ever taken Fen-Phen/Redux?.....() ()
5. Do you smoke?.....() ()
6. Do you use smokeless tobacco?.....() ()
7. Do you use controlled substances?.....() ()
8. Have you ever dealt with alcoholism?.....() ()

9. Are you allergic to or have you had any reactions to the following? **YES NO**
- Local Anesthetic (i.e. Lidocaine)..... () ()
- Penicillin or Other Antibiotics..... () ()
- Sulfa Drugs..... () ()
- Barbiturates.....() ()
- Sedatives.....() ()
- Codeine or Hydrocodone.....() ()
- Aspirin.....() ()
- Metals (i.e. Nickel, Mercury etc.).....() ()
- Latex.....() ()
- Other(please list) _____

10. Do you have persistent cough or throat clearing not associated with a known illness lasting more than 3 weeks?.....() ()
- (A) Are you using contraceptive medication?.....() ()
(C) If so, how many months? _____
- (B) Are you Pregnant?.....() ()
- (D) Are you nursing?.....() ()

11. For Women Only:

12. DO YOU HAVE ANY OF THE FOLLOWING?

- | Yes No | Yes No | Yes No |
|---|---|-----------------------------------|
| High Blood Pressure.....() () | Heart Disease.....() () | Chest Pains.....() () |
| Heart Attack.....() () | Cardiac Pacemaker.....() () | Easily Winded.....() () |
| Rheumatic Fever.....() () | Heart Murmur.....() () | Stroke.....() () |
| Swollen Ankles.....() () | Angina.....() () | Hay Fever/Allergies.....() () |
| Fainting / Seizures.....() () | Frequently Tired.....() () | Tuberculosis.....() () |
| Asthma.....() () | Anemia.....() () | Radiation Therapy.....() () |
| Low Blood Pressure.....() () | Emphysema.....() () | Glaucoma.....() () |
| Epilepsy/Convulsion.....() () | Cancer.....() () | Recent Weight Loss.....() () |
| Leukemia.....() () | Arthritis.....() () | Liver Disease.....() () |
| Diabetes.....() () | Joint Replacement, implant or Stent.....() () | Heart Trouble.....() () |
| Kidney Disease.....() () | Hepatitis A,B,C or Jaundice.....() () | Respiratory Problems.....() () |
| AIDS or HIV infection.....() () | Sexually Transmitted Disease.....() () | Mitral Valve Prolapse.....() () |
| Thyroid Problems.....() () | Stomach Troubles / Ulcer.....() () | Prolonged Bleeding.....() () |
| On Anticoagulation or Anti-rejection meds.....() () | | Other _____ |

DENTAL HISTORY

Name of previous dentist and location _____ Date of last dental exam _____

Are you experiencing any dental pain? YES () NO () If yes where? Upper _____ Lower _____ Left _____ Right _____

How long? _____ What are you taking for it? _____

- | | Yes | No | | Yes | No |
|---|-----|-----|--|-----|-----|
| 1. Do your gums bleed when brushing or flossing?..... | () | () | 8. Do you have frequent headaches?..... | () | () |
| 2. Are your teeth sensitive to hot or cold?..... | () | () | 9. Do you clench or grind your teeth?..... | () | () |
| 3. Are your teeth sensitive to sweet or sour?..... | () | () | 10. Do you bite your lips or cheeks frequently?..... | () | () |
| 4. Do you feel pain to any of your teeth?..... | () | () | 11. Have you ever had any difficult extractions?..... | () | () |
| 5. Do you have any sores or bumps in or near your mouth?..... | () | () | 12. Have you ever had any prolonged bleeding following extraction?..... | () | () |
| 6. Have you had any head, neck or jaw injuries?..... | () | () | 13. Have you had any orthodontic treatment?..... | () | () |
| 7. Have you ever experienced any of the following In your joints? | | | 14. Do you wear dentures or partials?..... | () | () |
| Clicking..... | () | () | If yes, how long? _____ | | |
| Pain (joint, ear, side of face) upon opening..... | () | () | 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?..... | () | () |
| Difficulty in opening or closing..... | () | () | 16. Have you ever seen a periodontist?..... | () | () |
| Difficulty in chewing..... | () | () | | | |

SMILE EVALUATION

Do you like your smile? () Y () N Are Your Teeth Straight? () Y () N Do you like the color of your teeth? () Y () N

Do you have spaces between your teeth you are unhappy with? () Y () N

Are you happy with the shape of your teeth? () Y () N Do you have old crowns or fillings that are unattractive to you? () Y () N

Based on these questions, if you could change your smile, what would you like to change? _____

Pharmacy Phone Number _____

FINANCIAL INFORMATION

Do you have dental insurance? Yes () No () If yes, Insurance company name _____

Policy Holder Name _____ Policyholder Date of Birth _____

Policy Holder SS# _____ Ins. Co. Phone Number _____

Employer Name _____ Group # _____

Do you have major medical insurance? Yes () No ()

We are happy to accept your dental benefits as payment of dental care. However, you must supply us with all the information for a completed claim form before we can accept it as payment. Charges not covered by dental insurance are the responsibility of the patient. Payment plans are available for everyone. Ask us for more information.

I have read the above and filled out the form to the best of my ability.

Patient Name Printed

Signature of Patient or Legal Guardian

Date

Doctors Initials