KLEIN DENTAL CENTER, PC
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) _____

HomeAddress_____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?.....( ) ( )

11. For Women Only:

(A)Are you using contraceptive medication?.....( ) ( )
(C) If so, how many months?_____

(B)Are you Pregnant?.....( ) ( )
(D)Are you nursing?.....( ) ( )

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		Heart Trouble.....	( ) ( )
Kidney Disease.....	( ) ( )	Stent.....	( ) ( )	Respiratory Problems.....	( ) ( )
AIDS or HIV infection.....	( ) ( )	Hepatitis A,B,C or Jaundice....	( ) ( )	Mitral Valve Prolapse	( ) ( )
Thyroid Problems.....	( ) ( )	Sexually Transmitted Disease.	( ) ( )	Prolonged Bleeding	( ) ( )
On Anticoagulation or		Stomach Troubles / Ulcer.....	( ) ( )	Other_____	
Anti-rejection meds.....	( ) ( )				

Have you used prescription medications for pain (or sedation, anxiety etc.) in the past 1-2 months? ( ) Yes ( ) No
Are you currently taking any prescription medications such as Lortab, Vicodin, Valium, Xanax or similar meds? ( ) Yes ( ) No

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
1.Do your gums bleed when brushing or flossing?.....	( )	( )
2.Are your teeth sensitive to hot or cold?.....	( )	( )
3.Are your teeth sensitive to sweet or sour?.....	( )	( )
4.Do you feel pain to any of your teeth?.....	( )	( )
5.Do you have any sores or bumps in or near your mouth?.....	( )	( )
6.Have you had any head, neck or jaw injuries?.....	( )	( )
7.Have you ever experienced any of the following In your joints?		
Clicking.....	( )	( )
Pain (joint, ear,side of face) upon opening.....	( )	( )
Difficulty in opening or closing.....	( )	( )
Difficulty in chewing.....	( )	( )
8.Do you have frequent headaches?.....	( )	( )
9.Do you clench or grind your teeth?.....	( )	( )
10.Do you bite your lips or cheeks frequently?.....	( )	( )
11.Have you ever had any difficult extractions?.....	( )	( )
12.Have you ever had any prolonged bleeding following extraction?.....	( )	( )
13.Haveyou had any orthodontic treatment?.....	( )	( )
14.Do you wear dentures or partials?.....	( )	( )
If yes, how long?_____		
15.Have you ever received oral hygiene instructions regarding the care of your teeth and gums?.....	( )	( )
16.Have you ever seen a periodontist?.....	( )	( )

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