4305 Garfield #225 Midland, TX 79705 432-685-7011 www.Boylesgeneraldentistrymtx.com

Welcome to our office!

We sincerely appreciate your choosing us as your dental office and look forward to serving your dental needs!

Patient's Name: ______________________________
(Last) (First) (Middle)

Patient's Date of Birth: __________ **Age:** ______ **Sex: (M) (F) Ht:** ___ ' ___ " **Wt.:** ______ lbs

Parent or Responsible person's name: ______________________________

Address **(of responsible person):** ______________________________

City, State, Zip Code: ______________________________

Telephone Numbers: ______________________________
(Home) (Business) (Cell)

Please circle phone # preferred for confirming appointments

Email address (also used for confirming appointments):______________________________

Occupation: ______________________ **Employer:** ______________________

Marital Status:(Single) (Married) (Divorced) (Widowed)**Spouse's Name:** ______________________

Spouse's Employer:______________________ **Bus. phone**______________ **Cell**______________

Dental Insurance Co: ______________________ **SS#:** ______________
(SS# required for filing insurance) **Spouses SS#:** ______________

Emergency contact person:______________________ **Phone:**______________

What is the reason for today's visit? ______________________________

Who can we thank for REFERRING YOU?______________________________

I agree to assume full financial responsibilty for all the dental treatment rendered. I consent to the dental procedures and anesthetics that are considered necessary for the proposed treatment that will be fully discussed and understood prior to proceeding. I also permit the release of any information to or from my physician as may be required and attesr that the following health history is accurate and fully disclosed to the best of my knowledge.

______________________________ ______________________________ **Date**__________
Signature of Patient, Parent or Guardian **Signature of Dentist/Witness**

Are you having any discomfort at this time? ________ How long since you have seen a dentist? ______________

How long since cleaning?____________ Have you ever had gum treatments?__________ When? ______________

Are you teeth sensitive to: Heat? ☐ Cold? ☐ Sweets? ☐ Pressure? ☐ Where?______________________

____
____
____
____
____
____
____
____

(See back for more)

Name BP: / P Date

---(Above for office use only)---

Have you had your teeth straightened? ________ When? ________ Do currently have bleeding gums? ________

Do you have any fear of dental treatment? None ________ Mild ________ Moderate ________ Severe ________

Are you comfortable having dental treatment with only local anesthetic? ________ Have you had wisdom teeth extracted? ________

Medical History:

Physician's Name: ____________________ Phone# ____________ Date Last Physical Exam _____

Are You Taking Any Medications Prescribed by a Physician?(Y) (N) List medications and dosage below

Are you **allergic** to any **medications** or **substances**? (Y) (N) List please ____________________

Do you have any of the following: *(Please indicate YES with a check mark)*

- Any Heart Disease ☐
- Heart Murmur ☐
- Mitral Valve Prolapse ☐
- High Blood Pressure ☐
- Low Blood Pressure ☐
- Circulatory Problems ☐
- Artificial Heart Valve ☐
- Hemophilia ☐
- Excessive Bleeding ☐
- Blood Transfusions ☐
- Anemia ☐
- Stroke ☐
- Heart Pacemaker ☐
- Artificial Joint ☐
- Fainting/Dizzy Spells ☐
- Autoimmune disease ☐
- Epilepsy ☐
- Do you SMOKE or dip snuff? ☐
- How much? ____________________
- Drug Addiction ☐
- Venereal Disease ☐
- HPV ☐
- Aphthous canker sores ☐
- Herpes/Fever Blisters/cold sores ☐
- AIDS or HIV pos ☐
- Malignancies (Cancer) ☐
- What kind? ____________________
- Radiation Treatments ☐
- Where radiated? ____________________
- Chemotherapy ☐
- Osteoporosis ☐
- Surgery requiring general anesthesia ☐
- Diabetes and Type ☐
- Liver Disease/Hepatitis ☐
- Thyroid Disease ☐
- Rheumatic Fever ☐
- Shingles ☐
- Glaucoma ☐
- Tonsillitis ☐
- Tuberculosis ☐
- Stomach Ulcer ☐
- Acid reflux ☐
- Asthma ☐
- Emphysema ☐
- Allergic Rhinitis ☐
- Sinus Problems ☐
- Kidney Disease ☐
- Arthritis ☐
- Cortisone Medication ☐
- When? ____________ ☐
- Are You Pregnant? ☐

Medical updates:

Date __________ Changes? ______________________________
Date __________ Changes? ______________________________
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