



1422 Main Street, Suite 207 • Southlake, TX 76092
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www.FuquaAdvancedDental.com

Patient's Name _____ Birthdate _____
Last First Middle
Address _____
Street City State Zip
Home Phone _____ Sex: M or F Social Security # _____ Occupation _____
Employer or School _____ Length of Employment: _____ Work Phone _____
Email Address _____ Cell Phone _____

Person Responsible for Payment _____
Last First Middle
Address _____
Street City State Zip
Relationship to Patient _____ Social Security # _____ Birthdate _____
Driver's License # _____ Home Phone _____
Employer _____ Occupation _____ Work/Cell Phone _____

Patient's Spouses Name _____
Last First Middle
Spouses Employer _____
Occupation _____ Length of Employment: _____ Work/Cell Phone _____

DENTAL INSURANCE INFORMATION (need copy of card)

Insured's Name (employee) _____
Insured's Birthdate _____ Insured's Social Security # _____
Insured's Address (if different from above) _____
Insured's Employer _____ Work Phone _____
Name of Insurance _____ ID # _____ Group # _____
Insurance Address _____ Phone # _____

EMERGENCY INFORMATION

Local Friend or Relative not living with you _____
Complete Address _____
Phone No. _____

GETTING TO KNOW YOU

Why did you select our office? _____
Whom may we thank for referring you? _____
Is another member of your family or relative a patient in our practice? _____

CONSENT FOR TREATMENT

I authorize Dr. Fuqua to perform procedures, including but not limited to: giving anesthetics and medications, taking radiographs and photographs, restoring and extracting teeth and other procedures necessary for my therapy. X-rays, photographs and other records will remain the property of Dr. Fuqua and may be used for publication and teaching purposes. I hereby understand that I am financially responsible for services provided which is customarily paid on the day the services are rendered, unless prior arrangements have been made.

SIGNATURE OF RESPONSIBLE PARTY RELATIONSHIP DATE

Patient Registration

Today's Date _____

Patient's Name _____
Last First Middle Birthdate

DENTAL HISTORY

Reason For Today's Visit _____

Dentist Name _____

Dentist Address _____ Dentist Phone # _____

Date of last dental care _____ Date of last dental X-rays _____

Have you ever had any teeth removed? _____ How long have teeth been missing? _____

Have these teeth been replaced? _____ How? Bridge Partial Denture Implant

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations _____ If yes, describe _____

Have you ever had a blood transfusion Yes No If yes, give approximate dates _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check if you have or have had any of the following:

<input type="checkbox"/> AIDS	<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cortisone Treatments	Describe _____	<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Angina Pectoris	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Respiratory Disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Artificial Heart Valves	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Fainting	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Asthma	<input type="checkbox"/> Frequent Chest Pains	<input type="checkbox"/> Implant Prosthesis	<input type="checkbox"/> Sickle Cell Trait
<input type="checkbox"/> Back Problems	<input type="checkbox"/> GI Problems	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/> Stroke
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Swelling of Feet or Ankles
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Headaches	<input type="checkbox"/> Mitral Valve Problems	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Nervous Problems	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Circulatory Problems		<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Venereal Disease

Are you presently, or have you ever been under the care of a physician during the past year? Yes No

Have you ever had a reaction to local anesthetic? Yes No

Have you ever experienced any complication or illness following dental treatment? Yes No

Do you have any diseases or conditions not listed above? Yes No

Do you use tobacco? (If yes, please circle and give frequency) Yes No

Smoke: Cigarettes Cigars Pipe Frequency: _____

Smokeless: Chewing Tobacco Snuff or "Dip" Frequency: _____

MEDICATIONS

ALLERGIES

List medications you are currently taking:

Aspirin Penicillin

Codeine Sulfa

Latex Other

Local Anesthetic

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____

Dentist Comments: