ASPEN
DENTAL HOUSE
UPTOWN - DALLAS

2617 Thomas Ave.
Dallas, TX 75204
Ph. (214) 979-3278

We warmly welcome you to our office. Please take a few moments to complete the following information so that we can better care for you. It is our goal to help you reach and maintain maximum oral health.

Name: ______________________________

I prefer to be called: ______________ Male Female

Birth date: ____________ SSN: ____________

Home address: ______________________________

____

Hm # ____________ Cell # ____________

Wk # ____________ Pgr # ____________

Email ______________________________

How do you prefer to confirm your appointments?

____

Employer: ______________________________

____

Occupation: ______________________________

Whom may we thank for referring you? __________

Other family members seen by us?

____

Previous / Present Dentist: ________________

Date of Last Visit : ________ Ph# __________

Dental Insurance

Primary Dental Insurance

Insurance Co. Name: ______________________

Address: ______________________________

Phone: ______________________________

Group # (Plan, Local, or Policy #) ______________

Insured's Name: ______________________

Relation: ______________________________

Insured's Birth date: ______________________

Insured's SSN: ______________________

Secondary Dental Insurance

Insurance Co. Name: ______________________

Address: ______________________________

Phone: ______________________________

Group # (Plan, Local, or Policy #) ______________

Insured's Name: ______________________

Relation: ______________________________

Insured's Birth date: ______________________

Insured's SSN: ______________________

In the event of an emergency, is there someone who lives near you that we should contact?

Name: ______________________________

Relation: ______________________________

Wk # ______________ Hm # ______________

A note for patients with dental insurance – We will assist you to maximize your insurance benefits, and we are happy to file claims to your insurance carrier and agree to accept payment from any carrier that offers an assignment of benefits, if you desire. We will do our best to calculate your available benefit amount, however, regardless of what your insurance plan pays, you are responsible for all fees.

Medical History

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

If yes, please explain: ______________________________

Are you taking any prescription/over the counter drugs? ☐ Yes ☐ No

If yes, please list: ______________________________

Do you use or smoke tobacco in any form? ☐ Yes ☐ No

Have you or do you take Redux/Fen Phen or Pondimin? ☐ Yes ☐ No

For women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No week# _______

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding	Y	N	Herpes/Fever Blisters
Y	N	Alcohol/Drug Abuse	Y	N	High Blood Pressure
Y	N	Anemia	Y	N	HIV+/AIDS
Y	N	Arthritis	Y	N	Hospitalized Any Reason
Y	N	Artificial Bones/Joints/Valves	Y	N	Kidney Problems
Y	N	Asthma	Y	N	Latex Allergy
Y	N	Blood Transfusions	Y	N	Liver Disease
Y	N	Cancer/Chemotherapy	Y	N	Low Blood Pressure
Y	N	Colitis	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Nervous/Anxious
Y	N	Diabetes	Y	N	Pacemaker
Y	N	Difficulty Breathing	Y	N	Psychiatric Problems
Y	N	Emphysema	Y	N	Radiation Treatment
Y	N	Epilepsy	Y	N	Rheumatic/Scarlet Fever
Y	N	Fainting Spells	Y	N	Seizures
Y	N	Frequent Headaches	Y	N	Shingles
Y	N	Glaucoma	Y	N	Sickle Cell Disease
Y	N	Hay Fever	Y	N	Sinus Problems
Y	N	Heart Attack	Y	N	Stroke
Y	N	Heart Murmur	Y	N	Thyroid Problems
Y	N	Heart Surgery	Y	N	Tuberculosis
Y	N	Hemophilia	Y	N	Ulcers
Y	N	Hepatitis	Y	N	Venereal Disease

Please list any other serious medical condition(s) that you have ever had:

____

____

Are you allergic to any of the following items?

Y	N	Aspirin	Y	N	Latex
Y	N	Codeine	Y	N	Penicillin
Y	N	Dental Anesthetics	Y	N	Tetracycline
Y	N	Erythromycin	Y	N	Other

Please list any other drugs you are allergic to:

Dental History

Why have you come to the dentist today? ______________________________

____

Many patients consult us for a 2nd opinion. Are you currently seeing another dentist for your dental needs? ☐ Yes ☐ No

If Yes, please explain: ______________________________

How would you describe the condition of your teeth and gums?
☐ Good ☐ Fair ☐ Poor

Are you currently in pain or discomfort with your teeth or gums?
☐ Yes ☐ No If yes, please explain:______________________________

How often do you brush your teeth? _____________ Floss? ________

Do your gums bleed when you brush? ☐ Yes ☐ No

Do your gums bleed when you floss? ☐ Yes ☐ No

Have you ever experienced pain in you jaw joint? ☐ Yes ☐ No

Have you ever been treated for TMJ symptoms? ☐ Yes ☐ No

If yes, please explain: ______________________________

Do you grind or clench your teeth? ☐ Yes ☐ No

I understand that this information is correct to the best of my knowledge. I understand it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I also give permission for the doctor or their staff to use any photos taken for lecturing, publishing, educational, or promotional purposes.

Signature ______________________ Date ______________

Patient portion is due in full at the time of treatment.

Updated Medical History/Consent

Signature ______________________________ *Date* ______________

Signature ______________________________ *Date* ______________

Signature ______________________________ *Date* ______________

Mark Whitfield, DDS

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