Advanced Dental Care of Austin
Justin J. D'Abadie D.D.S & Associates

Name: ______________________________ Preferred Name: _____________ Date: ______________

Marital Status: _______________________ E-mail ____________________________________

Date of Birth: ________________________ Social Security #: ____________________________

Address: ____________________________________ Home Phone: _______________________________

City & State: __________________________________ Work Phone: ________________________________

Zip code: ____________________________________ Cell Phone/Pager: ____________________________

Driver's License #: ______________________________ Employer: __________________________________

Occupation: ___________________________ Emergency Contact: __________________________

City & State: __________________________ Emergency Phone #: ___________________________

Referred by: ___________________________ Name of physician: _________________________________

Person responsible for account: ___________________ Name of insurance carrier: _____________________

INSURED INFORMATION (if different from above)**:**

Name of Insured: ________________________ Relationship to Insured: ______________________________

Date of Birth: ___________________________ Driver's License #: __________________________________

Social Security #: ________________________ Employer: ____

Occupation: ____________________________ Work street address: _________________________________

City & State: ____________________________ Zip code: ____

Medical History

1) Has there been any change in your health in the last year? Yes No
2) Have you ever been hospitalized, had a major operation or serious illness? Yes No
3) Date of your last visit to your doctor ___________ Reason for visit _________________________
4) Are you currently receiving treatment of regular medical care by your doctor Yes No
5) Are you allergic to or have you had any unusual reactions to any medications? Yes No

Please **explain** any **yes** answers and include the **question number** you are referencing below:

____

6) Are you currently taking any medications (prescription & over the counter drugs)? Yes No

If yes, what medications and for what conditions?

____

Have you ever had or been treated by a physician for: (circle responses and explain any yes answers)

7) Blood disorders such as hemophilia or anemia? Yes No

8) AIDS or HIV Yes No

9) Cancer, radiation treatments or chemotherapy Yes No

10) Diabetes or blood sugar problems Yes No

11) Tumors or growths Yes No

12) Allergies to metals, such as earrings or jewelry Yes No

13) Do you use tobacco products Yes No

a) If yes, how much and for how many years______________________

15) Damaged heart valves or artificial heart valves, including heart murmur, rheumatic heart disease

Yes No

16) Congenital heart problems Yes No

17) Heart trouble, heart attack, high blood pressure, stroke Yes No

a) Do you have pain in your chest upon exertion? Yes No

b) Are you short of breath after mild exercise? Yes No

c) Do your ankles swell? Yes No

18) Breathing problems, emphysema, tuberculosis or other lung problems Yes No

19) Asthma, hay fever or hives Yes No

20) Stomach, intestinal disease or ulcers Yes No

21) Hepatitis, jaundice or liver disease Yes No

22) Seizures, fainting spells, numbness or other neurological problems Yes No

23) Phobias, severe anxieties, depression, psychoses or other mental problems Yes No

24) Joint replacement or artificial joints Yes No

25) Women only, are you pregnant or breast feeding? Yes No

a) Due Date____________________

Please **explain** any **yes** answers and include the **question number** you are referencing below:

____

Dental History

26) What is your major dental concern? ____

27) Date of your last dental visit _____________ Reason for your last visit or series of visits ____________________

29) Date you last had dental x-rays ________________

30) Have you ever fainted during a dental visit? Yes No

31) Have you experienced an unusual reaction to a dental medication or anesthetic?

Yes No

32) Have you experienced prolonged bleeding following dental treatment? Yes No

33) Have you had any other complications following dental treatment? Yes No

34) Have you had any injury to your teeth, jaw or face? Yes No

35) Do you have any pain, popping or clicks in your jaw joints (TMJ) Yes No

36) Would you change anything about the appearance of your teeth? Yes No

Please **explain** any **yes** answers and include the **question number** you are referencing below:

____

SIGNATURE OF PATIENT: To the best of my knowledge, the answers I have given are true and accurate.

Signature____ Date__________________________

SIGNATURE OF PATIENT: I hereby acknowledge that I have been presented with a copy of Advanced Dental Care of Austin's **Notice of Privacy Practices.**

Signature____ Date__________________________