KATY TRAIL DENTAL

Welcome to our office! To assist us in serving you, please complete the following confidential form. This information is important for us to be able to provide you with the best possible care.

Date_____________

Last Name _________________________First Name ___________________________M.I_____

Preferred name_______________

Birth Date_____________________ Age _____ Male _____ Female _____

Cell/Work/Home______________________________________ Email Address____________________

Mailing Address____

City____________________ State__________________ Zip Code____________

Employer____________________ Occupation____________________

Married______ Single_____ Divorced_____ Widowed______

Spouse/Partner Name________________ Spouse/Partner Employer ____________________

Your Social Security #____________________

How did you hear about our office? ____________________

Emergency Contact ___________________ Relationship ____________ Phone #________________

Billing and Insurance Information: (If applicable or not provided already)

Dental Insurance Company _________________________ Group #___________________________

Employer Name_______________________

Insured's Name ______________ Insured's Date of Birth___________

Relationship to patient ______________________ Insured's ID # ________________________

Spouse/Partner's dental insurance company __________________ Group # ____________________

Spouse/Partner's Birth of Date__________ Spouse/Partner's Social Security#________________

If a minor, parent/guardian name____________________________Social Security #________________

Person financially responsible for account _____________ Relationship to patient________________

Address____

City_____________________________ State ______________ Zip Code_________________

KATY TRAIL DENTAL

Medical History Form

Name: ___________________________ Date: ____________

Date of Birth: ______________________ Height: _____Weight: _____

For the following questions, circle yes or no, whichever applies.

1. Do you feel you are in good health?..Yes No
2. My last physical exam was on __________/_____/________
3. Are you now under the care of a Physician?...Yes No
   If so, for what condition? ____
4. Have you had any serious illness, operation, or hospitalization?......................................Yes No
   If so, explain ____
5. Have you had an artificial joint replacement (knee, hip, shoulder, other)?............................Yes No
   If so, please explain and indicate if your doctor has told you to take antibiotic premedication prior to dental treatment?____
   ____
6. Are you taking or have you ever taken Bisphosphonates for Osteoporosis or Chemotherapy for Multiple Myeloma or other Cancer(s) (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa or Prolia)?……………………..……………………………………………………….................Yes No
7. Are you taking any medicine(s) including diet pills, non-prescription, vitamins, homeopathic or natural remedies?...Yes No
   If “Yes”, please list them here: ____
   ____
8. Have you had radiation therapy to the head, neck or jaws or treatment for a tumor or growth?...Yes No
9. Do you have or have you had any of the following diseases or health issues? *Please mark Yes or no and circle the ones that applies to you.*

	Yes	No		Yes	No
Damaged heart valve			Heart angina or chest pain upon exertion		
artificial valves			Hypothyroidism		
heart murmur			Hyperthyroidism		
Rheumatic heart disease			Arthritis		
Diabetes, Type I			Arteriosclerosis		
Diabetes, Type II			Osteoporosis		
Respiratory problem: emphysema, bronchitis, etc			Asthma		
HIV			AIDS		

	Yes	No		Yes	No
Swelling in the ankles			Tuberculosis		
seasonal allergies			Cancer		
Abnormal bleeding			Hepatitis A		
Anemia			Hepatitis B		
Fainting spells			Hepatitis C		
seizures			liver disease		
HPV + diagnosis			Low blood pressure		
Persistent swollen neck glands			High Blood Pressure		
Epilepsy			neurological disorder		
Depressed Immune System					

10. Are you allergic to or have you had a reaction to: *Please mark Yes or no and circle the ones that applies to you?*

	Yes	No		Yes	No
Local Anesthetics			Barbiturates or sleeping pills		
Iodine			Penicillin		
Codeine			Clindamycin		
other narcotics			Tetracycline		
Latex			Other antibiotics		
Aspirin			Other, please explain:		
Sulfa Drugs					

11. Do you have any other condition or disease you think the doctor should know about? .... Yes No
    If so, explain: ____
12. Do you smoke/chew or use Tobacco products including e-cigs, vaps, mods or juuls? .... Yes No
    How frequently? _________________
13. Do you use marijuna?.. Yes No No response
16. Is there any history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you?.. Yes No
17. Do you wear contact lenses?.. Yes No
18. Have you had the Gardasil vaccine?... Yes No

For Women Only

19. Are you pregnant? ……………………………. ………………………..……………… Yes No
20. Are you trying to become pregnant?... Yes No
21. Do you have problems associated with your menstrual period?..Yes No
22. Are you nursing?.. Yes No
23. Are you taking birth control pills?..Yes No

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Date: ____________________ Patient’s Signature: _____________________________________

Date: ____________________ Dentist’s Signature: _____________________________________

KATY TRAIL DENTAL

Dental History Form

Date___________________________ Patient Name_____________________________________

What is the main reason you are seeking dental treatment today? _______________________________

Approximate date of last dental visit ______________Name of previous dentist ____________________

What was done at your last dental visit? ____

Are you nervous about having dental treatment? ………………………………………………… Yes No

If "Yes", what is your biggest concern? ____

Do you use any special aids? (Sonic brush, Water Pik, etc.)? ……………………………………...Yes No

List: ____

Do you have any dental problems at this time? ………………………………………………….....Yes No

If "Yes", please describe? ____

Questions about your TEETH: Please Describe

Hot or cold sensitivity? …………………………… Yes No ____________________________________

Sensitivity to sweets? ……………………………..Yes No ____________________________________

Biting or chewing sensitivity? ……………………Yes No____________________________________

Loose teeth? ……………………………………..... Yes No ____________________________________

Food Impaction between teeth? ………………… Yes No____________________________________

Change in your bite? ………………………………Yes No____________________________________

Clench or grind while awake or asleep? ….……….Yes No____________________________________

Snore or have– Sleep Apnea?............................Yes No____________________________________

Mouth breather – awake or asleep?...................Yes No ____________________________________

Questions about your ORAL HYGIENE:

Do you brush regularly? ………..Yes No How often do you brush? **1x 2x 3x a day**

Do you rinse with fluoride or any other oral rinses? ……………………………………………….. Yes No

Do you floss?............................ Yes No How often do you floss? **1x 2x 3x a day**

Questions about your DENTAL HISTORY:

Have you had orthodontics (braces)? ....Yes No
Do you wear retainers?...Yes No
History of Periodontal Treatment (Deep Cleaning)? ....Yes No
Any former Oral Surgery?...Yes No
Any serious injury to head or mouth? .... Yes No
If so, describe____

Questions about your MOUTH & JAW:

Bleeding or sore gums?...Yes No
Bad breath, odors, or unpleasant taste?...Yes No
Frequent cold sores, blisters, lesions?...Yes No
Persistent and chronic hoarseness or unusual sore throat?.......................................Yes No
Swelling or lumps in the mouth?...Yes No
Clicking or popping of the jaw?..Yes No
Pain in joint, ear, or side of face?...Yes No
Difficulty opening or closing?..Yes No
Headaches, neck or shoulder aches?..Yes No

Questions about COSMETIC CONCERNS:

Are you satisfied with appearance of your teeth?...Yes No
Are you interested in Botox® and/or dermal fillers?..Yes No
Are you interested in whitening?...Yes No
Is there anything else you would like for us to know? ______________________________

Patient's Signature: ____________________________ Date:_________________________

Dentist's Signature: ____________________________ Date:_________________________

KATY TRAIL DENTAL

KTD NEW FINANCIAL POLICY:

Dental treatment is an investment in your overall health and well-being. Our goal is to make paying for your treatment as easy and straightforward as possible. It is our policy at KTD to collect for services rendered at the time of service. If dental insurance is not being utilized, a discount will be extended. If you will be utilizing dental insurance, as a courtesy to you, we will research dental benefits to the best of our ability prior to your appointment and we will file your dental claim under Katy Trail Dental. These dental benefit payments will be assigned and paid directly back to the patient by the insurance company. All treatment estimates are based on information provided by the insurance company and are not guaranteed of payment/coverage. Insurance is an agreement between the patient and the insurance company.

GENERAL CONSENT FOR NECESSARY IMAGING AND DENTAL EXAMINATION:

By signing below, I give permission for my dentist and his/her clinical team to take any necessary x-rays, photos, or study models to enable complete diagnosis of treatment.

CANCELLATION POLICY:

Any missed appointment with less than 48 hours notice given to the office is subject to a non-refundable missed appointment fee of $50. Flexible payment options are available through discussion with the office manager. Third party financing is abundantly available in our office.

WARRANTIES:

I understand we can never warranty the success of dental treatments but if I maintain my regular exams with x-rays and hygiene appointments at Katy Trail Dental at the time frame suggested by Katy Trail Dental, Dr. Bahramnejad will stand by her work if a reasonable repair needs to be made.

____

Patient Name

____ ______________

Patient Signature Date

____ ______________

Office Manager/KTD Authorized Representative Date