



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?.....
2. My last physical exam was on _____/_____/_____
3. Are you now under the care of a Physician?.....
If so, for what condition? _____
4. Have you had any serious illness, operation, or hospitalization?.....
If so, explain _____
5. Have you had an artificial joint replacement (knee, hip, shoulder, other)?.....
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)?.....
7. **Are you taking any medicine(s) including diet pills, non-prescription, vitamins, homeopathic or natural remedies?**.....
8. If "Yes", please list them here: _____
9. Have you had radiation therapy to the head, neck or jaws or treatment for a tumor or growth?.....
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		
Swelling in the ankles			Tuberculosis		

	Yes	No		Yes	No
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?

If so, explain: _____

12. Do you smoke/chew or use Tobacco products including e-cigs, vaps, mods or juuls?

How frequently? _____

13. Do you use marijuana?.....

16. Is there any history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you?.....

17. Do you wear contact lenses?.....

18. Have you had the Gardasil vaccine?.....

For Women Only

19. Are you pregnant?

20. Are you trying to become pregnant?.....

21. Do you have problems associated with your menstrual period?.....

22. Are you nursing?.....

23. Are you taking birth control pills?.....

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?

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

Do you use any special aids? (Sonic brush, Water Pik, etc.)?

List: _____

Do you have any dental problems at this time?

If "Yes", please describe? _____

Please Describe

Questions about your TEETH:

Hot or cold sensitivity?	_____
Sensitivity to sweets?	_____
Biting or chewing sensitivity?	_____
Loose teeth?	_____
Food Impaction between teeth?	_____
Change in your bite?	_____
Clench or grind while awake or asleep?	_____
Snore or have– Sleep Apnea?.....	_____
Mouth breather – awake or asleep?.....	_____

Questions about your ORAL HYGIENE:

Do you brush regularly?	How often do you brush? 1x 2x 3x a day
Do you rinse with fluoride or any other oral rinses?	
Do you floss?.....	How often do you floss? 1x 2x 3x a day

Questions about your DENTAL HISTORY:

Have you had orthodontics (braces)?
Do you wear retainers?.....
History of Periodontal Treatment (Deep Cleaning)?
Any former Oral Surgery?.....
Any serious injury to head or mouth?
If so, describe_____

Questions about your MOUTH & JAW:

Bleeding or sore gums?.....
Bad breath, odors, or unpleasant taste?.....
Frequent cold sores, blisters, lesions?.....
Persistent and chronic hoarseness or unusual sore throat?.....
Swelling or lumps in the mouth?.....
Clicking or popping of the jaw?.....
Pain in joint, ear, or side of face?.....
Difficulty opening or closing?.....
Headaches, neck or shoulder aches?.....

Questions about COSMETIC CONCERNS:

Are you satisfied with appearance of your teeth?.....
Are you interested in Botox® and/or dermal fillers?.....
Are you interested in whitening?.....
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
