Hutto Premier Dentistry

Thank you for visiting Hutto Premier Dentistry. We strive to make your dental visit as pleasant and comfortable as possible. Please help us by completing this form.

General Information:

Last Name _____ First _____ M.I. _____

Address _____ City _____ Zip _____

Phone: Home _____ Cell _____

Work _____ May we contact you at work? ☐ yes ☐ no

Email Address _____

Birth Date _____ ☐ Male ☐ Female

Employer _____ Driver's License _____

Social Security Number (this is required to file insurance claims)_____

Emergency contact name and number _____

How did you hear about our office? _____

Dental History:

When was your last dental visit? _____ Are you currently in pain? _____

How can we improve your oral health? _____

_____

Have you ever had any injuries to your teeth, jaw, or face? _____

_____

Is there anything you would like to change about your smile? _____

_____

Do your gums ever bleed? _____ Do you grind your teeth? _____

Do you use tobacco products? _____ Are your teeth ever sensitive? _____

Medical History:

Please circle if you currently have, or have ever had, any of the following conditions:

HEART	heart attack, heart murmer, mitral valve prolapse, rheumatic fever, congenital defect, low/high blood pressure, heart surgery, pace maker, other problems:
KIDNEY	bladder problems, urinary problems
LIVER/GI	hepatitis, jaundice, stomach/intestinal ulcers, gastritis, colitis, diarrhea, gastric reflux (GERD)
ENDOCRINE	diabetes, thyroid disease
HEMATOLOGICAL	stroke, blood transfusion, anemia, hemophilia, sickle cell anemia, prolonged bleeding, leukemia
LUNGS	asthma, chronic cough, emphysema/COPD, tuberculosis (TB)
NEUROLOGICAL	seizures, epilepsy, fainting, brain injury, mental disorder, headaches
EYES/HEARING	vision problems, glaucoma, earaches, hearing loss
DERMAL	latex allergy, shingles, rash, fever blisters, skin ulcers, psoriasis
IMMUNOLOGICAL	HIV infection, AIDS, hepatitis, STDs
SKELETAL	arthritis, osteoporosis, broken bones, joint replacement
OTHER	anxiety, alcohol/drug abuse, chemotherapy, radiation therapy

Please list any additional health problems: _____

Are you allergic to any medications? _____

Please list any medications you are taking: _____

_____

Height _____ Weight _____ Females: Are you pregnant? _____

Have you ever had surgery? _____

I have completed this form to the best of my knowledge. I give permission for Hutto Premier Dentistry to take any necessary diagnostic x-rays, photos, or study models required to enable complete diagnosis and treatment.

Signature*:* _____