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 help improve your health? ____

____

Have you ever had an injury to your teeth, jaw, or face? ___________________________________

Do you have anxiety about dental care? ____

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

____

Do your gums bleed? _____________________ Do you grind your teeth? _________________

Do you use nicotine products? ______________ Are your teeth sensitive? _________________

Medical History:

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

Heart health: heart attack pacemaker high blood pressure heart surgery valve replacement infective endocarditis

Lung health: asthma emphysema tuberculosis (TB)

Blood health: stroke excessive bleeding leukemia

Endocrine: diabetes thyroid disease

Immune health: HIV/AIDS hepatitis

Skeletal: osteoporosis joint replacement

Other: seizures fainting anxiety cancer chemotherapy radiation therapy

Are you allergic to, or have you ever had an adverse reaction to, any of the following? amoxicillin penicillin local anesthetics latex other: ________________________________

Please list additional health problems: ____

Please list medications you are taking: ____

____

Please list any surgeries: ____

____

Height ________ Weight _________ Females: Are you pregnant or nursing? ____________

I have completed this form to the best of my knowledge. I permit Hutto Premier Dentistry to take any necessary diagnostic X-rays, photos, or study models required to enable complete diagnosis and treatment. ***I understand that I will not receive today's therapy if I refuse to take any x-rays that my dentist deems necessary in delivering my care.***

Signature: ____ Date: ____________________