~Welcome~

Dripping Springs Family Dentistry, Inc.

Proudly serving Dripping Springs and Surrounding Communities for over 15 years!

Patient Information (CONFIDENTIAL)

Name _____ DOB_____SS#_____

Address _____City _____ State ____ Zip Code _____

Email _____Cell Phone _____

Please circle: Male/Female Minor/Single/ Married/ Divorced/ Widowed/ Separated

Emergency Contact Name: _____Phone_____Relationship_____

Whom me we thank for referring you?_____

Insurance Information

Primary Insurance Information

Name of Insured _____Cell Phone_____Relation to Patient_____

Insured's Address _____City _____ State_____Zip Code _____

SS# _____ DOB_____Name of Employer_____

Address of Employer _____City_____State____Zip Code_____

Insurance Company _____Group# _____**Sub/Member ID#/**_____

Ins. Co. Address _____City _____ State ___ Zip Code_____

Secondary Insurance Information

Name of Insured _____Cell Phone_____Relation to Patient_____

Insured's Address _____City _____ State_____Zip Code _____

SS# _____ DOB_____Name of Employer_____

Address of Employer _____City_____State____Zip Code_____

Insurance Company _____Group# _____**Sub/Member ID#/**_____

Ins. Co. Address _____City _____ State ___ Zip Code_____

Responsible Party

Name_____ Birth date _____ Relation to Patient _____

Address _____City _____ State_____Zip Code _____

Cell Phone _____ Work Phone_____Email _____

Employer Name:_____Occupation_____

Address _____City _____ State_____Zip Code _____

Patient Dental History

Name of Previous Dentist and Location _____Date of Last Exam _____

Please circle yes or no to the following questions:

Do your gums bleed while brushing or flossing? Yes/No **Do you have frequent headaches?** Yes/No

Are your teeth sensitive to hot or cold liquids/foods? Yes/No

Are your teeth sensitive to sweet or sour liquids/foods? Yes/No

Do you feel pain to any of your teeth? Yes/No

Do you have any sores or lumps in or near your mouth? Yes/No

Have you had any head, neck or jaw injuries? Yes/No If yes please explain_____

Have you ever experienced any of the following problems in your jaw?

Clicking Yes/No **Pain** (joint, ear, side of face) Yes/No **Difficulty in opening or closing** Yes/No **Difficulty in chewing** Yes/No

Do you clench or grind your teeth? Yes/No **Do you bite your lips or cheeks frequently?** Yes/No

Have you ever had any difficult extractions in the past? Yes/No

Have you ever had any prolonged bleeding following extractions? Yes/No

Have you had any orthodontic treatment (braces)? Yes/No

Do you wear dentures or partials? Yes/No If yes, date of placement _____

Have you ever received oral hygiene instructions regarding the care of your teeth and gums? Yes/No

Do you like your smile? Yes/No If no please explain_____

Authorization and Release I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient/Guardian X_____ Date _____