Hello & Welcome to Perfect Smiles Plano Family Dentistry!
Thank you for allowing us to help you with your dental needs.
Please fill out both sides of this questionnaire.

Patient's General Information

Date: _____/_____/_____

How were you referred to our office? _____

Purpose of today's visit: _____

Last Name: _____ First Name: _____

Male (☐) Female (☐) Married (☐) Single (☐) Child (☐) Date of Birth: _____/_____/_____

Social Security #_____ Driver License #_____

Home Address: _____ Apt #_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone:_____

Place of Employment: _____ Position: _____

Work Phone: ( ) _____Extension _____

E-Mail Address _____

Dental Insurance & Guarantor's Information

Insured Last Name: _____ Insured First Name: _____

Social Security of Insured: _____ Date of Birth of Insured: _____/_____/_____

Place of Employment: _____ Position: _____

Insurance Company Name: _____ Phone Number: _____

Relationship to Patient: _____Is patient covered under another dental insurance? _____

Dental History

Your main complaint or concern about your teeth: _____

Do you have a toothache or sensitive tooth? _____

Date of last dental checkup & cleaning: ___/___/___ Prior Dentist's Name? _____

Do you smoke or use any tobacco products? _____ Do you drink alcohol? _____

Have you ever been diagnosed with periodontal (gum) disease? _____

Do your gums bleed? _____ Are you concerned about bad breath? _____

Do you wear dentures/partials? _____ Do you grind your teeth? _____

Are you happy with your smile? If not why? _____

Would you like to know how we could help you to improve your smile cosmetically? _____

Are you happy with the color, shape and alignment of your teeth? _____

Are you interested in whitening your teeth? _____

Medical Information

Emergency Contact Name: _____Relationship: _____Phone #: _____

Physician's Name: _____ Phone Number: _____

Are there any medical precautions to dental procedures? _____

Have you ever been hospitalized for any reason? _____

If yes, please explain: _____

Have you ever been told you need to be pre-medicated with antibiotics before dental procedures? _____

Medications & Drug Allergies

List ALL medications you currently take: _____

List ALL drug allergies: _____

Medical History*Past or Present* *(Please read thoroughly and check answers carefully!)*

Yes	No		Yes	No		Yes	No	
☐	☐	**Heart Murmur**	☐	☐	**Mirtral Valve Prolapse**	☐	☐	**Rheumatic Fever**
☐	☐	HIV +/ AIDS	☐	☐	Hepatitis (A,B,C)	☐	☐	Diabetes
☐	☐	Prolonged Bleeding	☐	☐	High Blood Pressure	☐	☐	Sinusitis, Hay Fever
☐	☐	Drug/Chemical Dependence	☐	☐	Asthma	☐	☐	Venereal Disease
☐	☐	Liver Disease	☐	☐	Kidney Disease	☐	☐	Epilepsy/Seizure
☐	☐	Arthritis/Joint Disease	☐	☐	Thyroid Condition	☐	☐	Tuberculosis
☐	☐	Emphysema	☐	☐	Dizziness/Fainting	☐	☐	Anorexia/Bulimia
☐	☐	**Surgical Implants**	☐	☐	Anemia	☐	☐	Nervous Disorders
☐	☐	Stomach Ulcers	☐	☐	Cancer	☐	☐	Skin Disorders
☐	☐	Latex Allergies	☐	☐	Immune Disorders	☐	☐	Blood Disease
☐	☐	Phen-Phen or Diet Medications	☐	☐	**Heart Pacemaker**	☐	☐	Sudden Weight Loss

If yes please explain: _____

Have you ever been diagnosed with Osteoporosis? Yes ☐ No ☐
Have you ever taken Fosamax or any other medication for treatment of bone density? Yes ☐ No ☐

Explain: _____

Women Only: Are you pregnant? Y ☐ N ☐ Birth control pills? Y ☐ N ☐ Are you nursing? Y ☐ N ☐

PLEASE READ CAREFULLY AND SIGN:

I have answered all above questions to the best of my knowledge. I realize it is solely my responsibility to inform this office and Dr. Tehrani of any medical conditions, allergies, or changes in my medical history. I have reviewed this form completely and made necessary changes.

I consent to treatment & diagnoses of myself & any minor dependant by Dr. Tehrani, Plano Family Dentistry & staff.

Even though Plano Family Dentistry gladly accepts my insurance assignment, that in no way releases me from financial liability if my insurance company denies payment of my bill in whole or part.

All charges past 90 days, after submission to Insurance Company, are the patient's responsibility.

I understand that I am responsible for all dental charges I incur.

I allow Dr. Tehrani to release all pertinent information to physicians, insurance companies or other health care providers solely for the purpose of diagnosed treatment, remedy, conference or to help pay my dental bill.

My signature below allows Plano Family Dentistry to send claims to my insurance company and authorizes payment directly to this dental office. I understand this above statement and my signature below verifies this.

We reserve the right to charge for appointments cancelled or broken without 24 hours advance notice.

Signature_____ Date:_____

(Parent Signature If Minor)