

**Drs. Van Wart**

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**PATIENT INFORMATION**

**DATE:**

Name \_\_\_\_\_ Birthdate \_\_\_/\_\_\_/\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email \_\_\_\_\_

Pick Appropriate Choice: \_\_Minor \_\_Single \_\_Married \_\_Divorced \_\_Widowed \_\_Separated

Patient's or Parents Employer: \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Business Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse Or Parents Name \_\_\_\_\_

Employer: \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

If a Student: Name of School Attending \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Whom May We Thank For Referring you? \_\_\_\_\_

Person To Contact in Case of Emergency: \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Alternate # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**RESPONSIBLE PARTY**

Person Responsible for Account \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Birthdate \_\_\_/\_\_\_/\_\_\_ Social Security# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Insurance Information- Dental Only**

Subscriber's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_/\_\_\_/\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date Employed \_\_\_/\_\_\_/\_\_\_

Employers Name: \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Insurance Name: \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Member # \_\_\_\_\_ Group # \_\_\_\_\_

# MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you had any serious illnesses or operations?  Yes  No If Yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No If yes, give approximate dates \_\_\_\_\_

(Women) Are you pregnant?  Yes  No Due date: \_\_\_\_\_ Nursing?  Yes  No Taking birth control pills?  Yes  No

	Yes	No		Yes	No		Yes	No		Yes	No
Allergies, hay fever sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Circulatory problems	<input type="checkbox"/>	<input type="checkbox"/>	Any Immune Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	Skin rash	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis, Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Corticoid treatments	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Slow healing wounds	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valves	<input type="checkbox"/>	<input type="checkbox"/>	Cough, persistent or bloody	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of feet or ankles	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Required Hospitalization?	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Have you used steroids?	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Date of last episode _____			Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatment	<input type="checkbox"/>	<input type="checkbox"/>	Tumor or growth on head or neck	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding abnormally with _____	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
extractions or surgery			Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Veneral disease	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease, clotting disorders	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	Weight loss, unexplained	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
Chemical dependency	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>			

List medications you are currently taking: \_\_\_\_\_

Allergy to Penicillin, Aspirin or Other Drugs: Yes  No  Specify: \_\_\_\_\_

# DENTAL HISTORY

Reason for today's visit \_\_\_\_\_ Date of last dental visit \_\_\_\_\_

Former dentist \_\_\_\_\_ Date of last dental x-rays \_\_\_\_\_

	Yes	No		Yes	No		Yes	No
Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	Clench or grind teeth	<input type="checkbox"/>	<input type="checkbox"/>	Orthodontic treatment	<input type="checkbox"/>	<input type="checkbox"/>
Blisters on lips or in mouth	<input type="checkbox"/>	<input type="checkbox"/>	Growths or sore spots in your mouth	<input type="checkbox"/>	<input type="checkbox"/>	Nitrous Oxide (laughing gas)	<input type="checkbox"/>	<input type="checkbox"/>
Burning sensation on tongue	<input type="checkbox"/>	<input type="checkbox"/>	Gums swollen, tender or bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Periodontal treatment	<input type="checkbox"/>	<input type="checkbox"/>
Chew on one side of mouth	<input type="checkbox"/>	<input type="checkbox"/>	Jaw pain or tiredness	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to pressure or irritants (cold, heat or sweets)	<input type="checkbox"/>	<input type="checkbox"/>
Cigarette, pipe or cigar smoking	<input type="checkbox"/>	<input type="checkbox"/>	Lip or cheek biting	<input type="checkbox"/>	<input type="checkbox"/>			
Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	Loose teeth or broken fillings	<input type="checkbox"/>	<input type="checkbox"/>			
Food collection between the teeth	<input type="checkbox"/>	<input type="checkbox"/>	Mouth breathing	<input type="checkbox"/>	<input type="checkbox"/>			

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

Have you ever had an allergic reaction or allergic symptoms to Novocaine, local or general anesthetics?  Yes  No

Have you had trouble from previous dental care?  Yes  No \_\_\_\_\_

# AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Signature of patient or parent if minor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of doctor

\_\_\_\_\_  
Date