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)