PEOPLE'S DENTAL CARE, P.A. 100 W. CENTEX EXWY, STE 110 HARKER HEIGHTS, TX 76548
DR. TABREENA V.M. WALKER *"Creating Happy Healthy Smiles"* 254-699-7009

Please Complete Medical and Dental History Below:

DENTAL HISTORY When was your last dental visit? ____________________ Where? __________________________
What is the Name /Phone # of your last dentist? ____
Have you taken dental x-rays in the last 12 months? Y N Have you had a cleaning in the last 6 months? Y N
Are you allergic to Latex? Y N Are you in dental pain today? Y N Do you grind/clinch your teeth? Y N
Do you have oral or facial piercings? Y N

SOCIAL HISTORY What sport do you play? _______________ What instrument do you play? ______________
Do you chew tobacco, smoke cigarettes/cigars? Y N If yes, How Much? ___________________________
Do you drink Alcohol? Y N If Yes, How Much? ___________________________
If you use illegal drugs, what type and how often? ____
(Not answering this question truthfully can be detrimental to your health- responses are confidential)

MEDICAL HISTORY Physician's Name/Phone: _______________________________ Last Visit: _________

Have you ever had or do you currently have any of the following conditions: Circle: Yes or No

AIDS/HIV	Y	N	Emphysema	Y	N	Radiation Treatment	Y	N
Anemia	Y	N	Epilepsy	Y	N	Respiratory Disease	Y	N
Arthritis/Rheumatism	Y	N	Eczema/Psoriasis	Y	N	Rheumatic Fever	Y	N
Artificial Heart Valves	Y	N	Fainting/Dizziness	Y	N	Scarlet Fever	Y	N
Addiction/Dependency	Y	N	Glaucoma/Eye Problems	Y	N	Obesity/Anorexia/Bulimia	Y	N
Artificial Joints/Pins	Y	N	Headaches	Y	N	Shortness of Breath	Y	N
Asthma/Bronchitis	Y	N	Heart Murmur/ Angina	Y	N	Sinus Troubles	Y	N
Acid Reflux	Y	N	Heart Problems/Pacemaker	Y	N	Strep Throat	Y	N
Back Problems	Y	N	Heart Attack	Y	N	Immune Compromised	Y	N
Bleeding Abnormally	Y	N	Heart lesions-Congenital	Y	N	Skin Disorder/Rashes	Y	N
Blood Disease	Y	N	Hepatitis Type _______	Y	N	Special Diet	Y	N
Cancer/Chemotherapy	Y	N	High Blood Pressure	Y	N	Swollen Feet /Ankles	Y	N
Cystic Fibrosis	Y	N	Hysterectomy/Hormone Therapy	Y	N	Swollen Neck Glands	Y	N
Cholesterol – High	Y	N	Jaundice	Y	N	Thyroid Problems	Y	N
Circulatory Problems	Y	N	Jaw Pain/Jaw Surgery	Y	N	Tonsillitis	Y	N
COPD	Y	N	Kidney Disease	Y	N	Tuberculosis	Y	N
Cough, Persistent	Y	N	Liver Disease	Y	N	Tumor/Growth on Head/Neck	Y	N
Diabetes	Y	N	Low Blood Pressure	Y	N	Ulcers/Digestion Problems/Chron's	Y	N
Dental Implants	Y	N	Lupus/Fibromyalgia	Y	N	Unexplained Weight Loss	Y	N
Depression/ADHD/PTSD	Y	N	Multiple Sclerosis	Y	N	Venereal Disease	Y	N
Are you Nursing?	Y	N	Nervous Problems/Anxiety	Y	N	Use male enhancement drugs?	Y	N
Are you Pregnant?	Y	N	Psychiatric Care	Y	N	Do you take Birth Control?	Y	N

List any medications you are currently taking and the correlating diagnosis and dosages: _______________________
____
____

List all drug/medications you are ALLERGIC to: ____
____

Medical HX Reviewed: Doctor Signature: ____ Date: ____________

Medical Hx Updated: ______________ Doctor Signature: _____________________________ Date: ____________

Medical Hx Updated: ______________ Doctor Signature: _____________________________ Date: ____________

PEOPLE'S DENTAL CARE, P.A. DR. TABREENA V.M. WALKER 254-699-7002

100 W. CENTEX EXWY, STE 110 HARKER HEIGHTS, TX 76548 *"Creating Happy Healthy Smiles"*

Confidential Patient Registration Form Today's Date: ________________

(REQUIRED INFORMATION**)

**Last Name: **MI: **First Name:

**Address: **City: **State: **Zip Code:

**Home Phone: **Cellular Phone: **Work Phone:

E-mail Address: What do you prefer to be called? Occupation:

**Birth Date: **Soc. Sec. # **Driver's Lic# **Male___/Female___

(Check One) ___Minor/Student ___Married ___Single ___Divorced

Patient or Parent's Employer: May we contact you at your job for appointments? Yes / No

Employer Address: City: State/Zip Code:

Who may we thank for referring you? Emergency Contact – Name & Phone #

RESPONSIBLE PARTY

**Name of Person Responsible for this account: ______________________________ Birth Date: __________

Relationship to Patient: ______________ ___ ** Driver's Lic#: ___________** Soc. Sec #: ________________

Employer: ____ _____ Work Phone: ____________________

DENTAL INSURANCE INFORMATION

**Name of Policy Holder: ________________________________ **Driver's Lic #: ______________

**Birth date: ___________ Relationship to patient: ______________ ** Soc. Sec #: ________________

**Name of Insurance Company: ___________________________ Group #: ____________________

Insurance Company Address: City: State/Zip Code

AUTHORIZATION OF INFORMATION RELEASE & PAYMENT PROTOCOLS

I hereby certify that I have read and understand the information above as well as the People's Dental Care, P.A. clinic policies. The questions above and the medical history on the reverse have been accurately answered. I understand that providing incorrect information on my medical/dental history can be dangerous to my health. I authorize the dentist/PDC to release any information including diagnosis and record of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practioners. I authorize and request my insurance company to pay directly to the dentist benefits otherwise payable to me. I understand that my insurance may pay less than the actual bill for services and that I am responsible for expenses incurred. I understand and agree to be responsible for all services rendered and charges on behalf of myself or my dependents. I understand that digital photos of my mouth/teeth may be used for patient education and marketing and that my confidentiality/identity will remain intact.

XX Signature of Patient (or Parent if minor) ________________________________Date: __________