WACO ORAL SURGERY AND DENTAL IMPLANTS

7030 SANGER AVE ▪ SUITE 100 ▪ WACO, TEXAS ▪ 76712
Larry J. Pritchard, DDS

PATIENT INFORMATION

DATE:	Account #:

□ Mr. □ Ms. □ Mrs. □ Rev. □ Miss □ Dr.	Last Name	First	Middle	Date of Birth	Age

Street Address:	Social Security #: Driver License #:	Gender: ☐ Female ☐ Male
City:	Home Phone:	Cell Phone:

State:	Zip:	Email:

Full-Time Student: □ Yes □ No Year of Graduation: School Name:	Status: □ Child □ Single □ Widowed □ Married □ Divorced □ Other:

Employed by:	Occupation:	Business Phone: ( )

Business Street Address:	Business City:	Business State:	Business Zip:

Physician:	City:	Telephone: ( )

Dentist:	Were you referred to us by your dentist? Yes _____ No _____

If not referred by your dentist, how did you find us? □ Former Patient Referral □ Phone Book □ Website □ Family/Friend Referral

If referred by someone other than your dentist we would like to acknowledge them through our Referral Program. Please include their contact information:

Name:	Home Address:	Phone: ( )

Emergency Contact Name (not a member of your household):	Relationship to patient:	Home Phone: ( )

Contact Address:	Employer:	Work Phone: ( )	Cell Phone: ( )

SPOUSE INFORMATION

Name:	Date of Birth:	Social Security #:	Driver License #:
Home Address:		Home Phone:	Cell Phone:
Employer:	Occupation:	Business Phone:	
Employer Address:		Email:	

PATIENT SIGNATURE____**DATE**____________________________________

Do you have Dental Coverage? Yes____ No_____ Carrier Name________________________ Medical Carrier Name ____________________

PLEASE COMPLETE – RESPONSIBLE PARTY INFORMATION – IF PATIENT UNDER 18
This is information about the parent of guardian with the patient today – not information about the insured

FATHER

Name:	Date of Birth:	Social Security #:	Driver License #:
Home Address:		Home Phone:	Cell Phone:
Employer:	Occupation:	Business Phone:	
Employer Address:		Email:	

MOTHER

Name:	Date of Birth:	Social Security #:	Driver License #:
Home Address:		Home Phone:	Cell Phone:
Employer:	Occupation:	Business Phone:	
Employer Address:		Email:	

____ _______________________________

Signature of Parent or Responsible Party REQUIRED if patient is under 18 years old   Relationship if other than parent

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Confidential Medical Questionnaire

THIS FORM IS HIPPA COMPLIANT TO ENSURE PRIVACY

Please Print

First Name		**Last Name**		**Height**		**Weight**		**Age:**	
Primary Care Physician	Dr.			**Office Use**					

List All Medications (Prescription and Non-Prescription)				**List All Allergies (drugs, food, latex, tape, etc.)**
Medication Name	**Milligram**	**frequency**		
1.				
2 .				
3.				
4 .				
5.				
6.				
7.				

LIST HOSPITALIZATIONS IN THE LAST 5 YEARS			
Date	**Reason for Admission**	**Surgery?**	**Any adverse outcome?**

Have you ever had a reaction to local or general anesthesia?	Yes ☐ No ☐
If Yes, please describe:	

CHECK ALL THAT APPLY		
☐ Stroke	☐ Emphysema	☐ Organ Transplant
☐ Heart Attack	☐ Pneumonia	☐ Diabetes
☐ Chest Pain (Angina)	☐ Tuberculosis	☐ Seizures (Epilepsy)
☐ Irregular Heart Beat	☐ Hepatitis (Yellow Jaundice)	☐ Cancer
☐ Congenital Heart Disease	☐ Kidney or Bladder Trouble	☐ Radiation Therapy/Chemotherapy for cancer
☐ Replacement Heart Valve	☐ Thyroid Disease	☐ Ulcers
☐ Heart Murmur	☐ Arthritis	☐ Nervous Disorders
☐ High Blood Pressure	☐ Blood Disease	☐ Alcohol Abuse
☐ Pacemaker/Defibulator	☐ Anemia	☐ Drug Abuse including Marijuana
☐ Rheumatic Fever	☐ Syphilis or Venereal Disease	☐ Free or Excessive Bleeding
☐ Asthma	☐ AIDS/HIV	☐ Tobacco Abuse
☐ Shortness of Breath	☐ Bone Density Medication	☐ TMJ Problems
☐ Congestive Heart Failure	☐ Diet Medication	☐ Snoring/Sleep Apnea
☐ COPD	☐ Blood Thinners	☐ Total Hip/Joint Replacement

FOR FEMALE PATIENTS	
Are you pregnant?	Yes ☐ No ☐

Note: Patients taking birth control pills are advised that medications given during your treatment (i.e. antibiotics) can decrease the effectiveness of birth control pills. Therefore, other measures to avoid pregnancy are recommended.

To the best of my knowledge the above information is correct. I WILL NOT HOLD MY DOCTOR(S) OR ANY MEMBERS OF THEIR STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I HAVE MADE IN COMPLETION OF THIS FORM.

Patient Signature or Parent if minor	**Date**	**Staff Signature**
		Doctor Initials