



Dr. Max Teja, DDS
 Laser & Cosmetic Dentistry
 4331 College Hills Blvd.
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 325-223-2373

Confidential New Patient Information

Thank you for choosing us as your dental care team. We hope we can make your visits with us as pleasant as possible. If there is anything we can do to help with this, please let us know. Both state and federal law require us to obtain information on each patient. Please take a moment to fill out this form as completely as possible. Please note that our computer sets up accounts by families, under the name of the head of the household. Do not hesitate to ask us for assistance in completing this form.

New Patient Registration

Today's Date: ___/___/___ Soc. Sec. No. ___-___-___

Patient's Name: ^{Mr} _{Dr} ^{Mrs} _{Ms} ^{Miss} _____ Home Phone (____) _____

Home Address: _____ Date of Birth ___/___/___
Street City Zip

Minor Married Single Widowed Divorced Age _____

If patient is a minor, please list parents names: _____ ; _____
↓ Father ↓ Stepfather ↓ Mother ↓ Stepmother

Person Responsible for Account/Head of Household: _____ Soc. Sec. No. ___-___-___

Address (if different from above): _____ Driver's Lic. # _____
Street City Zip

Married Divorced Single Stepparent Guardian Date of Birth ___/___/___

Employer: _____ Position: _____ Business Phone (____) _____

Person to Contact in Emergencies: _____ Relation: _____ Phone (____) _____

Referred by: _____ Payment Method: Cash Credit Card Check

Do you have Dental Insurance to assist you in the payment of your account? No Yes, please complete the following section.

Dental Insurance Information

Please complete this section if you have dental insurance. If you do not know some of the information, we may, just ask.

Primary Insurance

Insured's Name _____
 Soc. Sec. No. ___-___-___
 Date of Birth ___/___/___
 Date of Employment ___/___/___
 Employer _____
 Insurance Company _____
 Policy Number (if known) _____
 Insurance Company Phone No. _____

Secondary Insurance

Insured's Name _____
 Soc. Sec. No. ___-___-___
 Date of Birth ___/___/___
 Date of Employment ___/___/___
 Employer _____
 Insurance Company _____
 Policy Number (if known) _____
 Insurance Company Phone No. _____

Dental History

Reason for Today's visit: _____

How long since your: last dental visit? _____ last X-rays? _____ last cleaning _____

Do you have? (please circle)

Or have your ever had? (please circle)

Cavities/Decay
 Bleeding gums
 Abscesses
 Sensitive teeth
 Clicking/Popping jaw joints
 History of thumbsucking
 Loose/Missing teeth
 Broken/Missing fillings
 Pain in teeth, gums, jaws
 Grinding teeth at night
 Clenching jaws
 Unsightly teeth

Root canal Therapy
 Gum disease Therapy
 TMJ Therapy
 Wisdom teeth removed
 Braces
 Cosmetic Dentistry
 Offensive breath
 Partials/Dentures
 Oral surgery while asleep
 Fainting in a dental office
 Treatment with laughing gas
 Very bad dental experience

Any other information we should know about your dental health: _____

please continue on reverse side _____→

Confidential Medical History

Today's date: _____

Please carefully complete this medical history form as the information you provide *may seriously affect your treatment.*

Patient's Name: _____

Medical History

Please review these areas of your medical history and indicate those responses that apply or provide other information requested.

Do you have or have you ever had? (Please circle Yes or No)

- | | | | |
|--|---------------------------------|-----------------------------|------------------------|
| Y N High Blood Pressure requiring medication | Y N Blood Disease like Leukemia | Y N Cancer | Y N Other Lung Disease |
| Y N Heart Attack, When _____ | Y N Sickle Cell Anemia | Y N Radiation Therapy | Y N Stomach Disease |
| Y N Heart Surgery (Bypass), When _____ | Y N Stroke, When _____ | Y N Chemotherapy | Y N Kidney Disease |
| Y N Heart Valve Surgery, When _____ | Y N Angina | Y N Cancer Surgery | Y N Liver Disease |
| Y N Pacemaker, When _____ | Y N Abnormal Bleeding | Y N Diabetes | Y N Eye Surgery |
| Y N Other Heart Disease, What _____ | Y N Aneurism | Y N Tobacco Use | Y N AIDS/HIV positive |
| Y N Heart Murmur | Y N Difficulty in Breathing | Y N Asthma | Y N Headache/Migranes |
| Y N Rheumatic Fever, When _____ | Y N Anemia | Y N Hepatitis A(infectious) | Y N STD/VD |
| Y N Blood Transfusion, When _____ | Y N Emphysema | Y N Hepatitis B(serum) | Y N Herpes/Shingles |
| Y N Joint Replacement, What _____ | Y N Nervous/Emotional Disorder | Y N TB/Night Sweats | Y N Ulcers |
| Y N Hemophilia | Y N Sinus Trouble | Y N Thyroid Disease | Y N Recreational Drugs |
| Y N Cosmetic Surgery | Y N Epilepsy/Seizures | Y N Arthritis | |

Do You Have Any Other Condition, Disease or Problem NOT Listed: _____

Any major operations: _____

Do You Take? Coumadin Insulin Cortisone Thyroid Medicine Nitroglycerin Oral Contraceptives (Please list all medications, including these, below)

Physician: _____ Phone: () _____

Physician: _____ Phone: () _____

Have you been told you are allergic to the following?(Please check)

- | | | | | |
|--|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------|
| <input type="checkbox"/> Penicillin, Ampicillin, Amoxicillin | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Keflex | <input type="checkbox"/> Bleach |
| <input type="checkbox"/> Codeine, Demerol | <input type="checkbox"/> Tylenol | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Pollens/Dust | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> General Anesthetics | <input type="checkbox"/> Iodine | <input type="checkbox"/> Latex | <input type="checkbox"/> Insect Bites | <input type="checkbox"/> Metals |

Any Other Allergies: _____

Please list any medications you are currently taking:

Which pharmacy are you currently using? Script Shoppe Davenport's Other: _____

Ladies: Are you now pregnant or suspect you might be? No Yes (Due Date: _____) Nursing? No Yes

Are you taking birth control pills? No Yes Hormone replacement? No Yes

Would you like to talk privately with Dr. Teja about any aspect of your medical or dental history? Yes No

Consent For Treatment for: _____

Please print patient's name

I attest that to the best of my knowledge the information provided is accurate and complete. Any changes in my health status or medications will be reported to Dr. Teja at the next dental visit following the change. I authorize Dr. Teja or his representatives to take radiographs, study models, photographs, and any other diagnostic aids deemed appropriate to make a thorough diagnosis and to develop proper treatment recommendations. I also authorize Dr. Teja to perform any and all forms of treatment, medication, and therapy that may be indicated and further authorize and consent that he choose and employ such assistance as he deems fit. I understand that the use of anesthetic agents embodies a certain risk.

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made in advance. I further understand that a 1.5% finance charge (18% annually) may be added to any balance over 60 days old. In the event of default, I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney's fees as may be required to collect the debt.

Signed: _____ Date: _____
 Patient
 Parent
 Guardian

Reviewed: _____ / _____ / _____