Creekwood Dental Arts

New Patient Health History

Contact@CreekwoodDentalArts.com

CreekwoodDentalArts.com

7911 Woodway Drive | Waco, TX 76712-3866

P: (254) 772-3632 F: (254) 772-7856

Patient Name: * _____ _____ ____ _____
Last Name First Name MI Preferred Name

Title: _____ **Gender:** * ◯ Male ◯ Female **Family Status:** * ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/Dr/Etc

Date of Birth (DOB): * _____ **SSN:** * _____ - _____ - _____ **Prev. Visit:** _____

Email Address: _____

Phone: * _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext.

Address: * _____ _____
Address Line 1 Address Line 2

_____ _____ _____ **Driver's License/State:** * _____
City State Zip Code

The following questions apply to your DENTAL insurance only:

Name of Insurance Policy Holder (PH):

_____ _____ _____ **Member ID #:** _____
Last Name First Name MI

Policy Holder (PH) SSN: _____ - _____ - _____ **PH's DOB:** _____ **Group #:** _____

Policy Holder's Employer Name: _____

Insurance Name: _____ **Insurance Phone Number:** _____

Patient's Relationship to Policy Holder: ◯ Self ◯ Spouse ◯ Child ◯ Other

In an emergency, who should be notified? Please enter name, phone number, and relationship below:

Emergency Contact: *

_____ (_____) _____ - _____ _____

_____ (_____) _____ - _____ _____

What is your most important concern today:

_____

_____

Are you currently taking any medications (including prescription, OTC medications, vitamins, and supplements)? If yes, please list all medications and dosages below: *

◯ Yes ◯ No

Medications:

_____

_____

_____

_____

_____

Red asterisk (*) signifies a required field.

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Do you take pre-medication for dental procedures (antibiotics)? * ◯ Yes ◯ No
If so, please list the antibiotic/medication you take prior to dental procedures (ex: amoxicillin, clindamycin):

_____

Do you have any allergies and/or allergies to medications? If yes, please list all allergies below: * ◯ Yes ◯ No

_____
_____
_____
_____

Have you ever had surgery? If yes, please list all surgeries. * ◯ Yes ◯ No

Surgeries:

_____
_____

Have you ever been hospitalized? If yes, please list all hospitalizations. * ◯ Yes ◯ No

Hospitalizations:

_____
_____

Name of physician, approximate date of last physical exam, and physician's phone number. *

_____ ____/____/_____ (_____) _____ - _____
_____ ____/____/_____ (_____) _____ - _____
_____ ____/____/_____ (_____) _____ - _____

Caries/Tooth Decay (select all that apply): *

☐ Consider yourself cavity prone
☐ Consume any citrus-flavored beverages
☐ Consume sugary foods on a regular basis
☐ Have holes, pitting, or notches in your teeth
☐ Dry Mouth
☐ Heartburn
☐ None

If any responses need further clarification, please describe below:

_____
_____

Periodontal Disease (select all that apply): *

☐ Been told you have gingivitis or gum disease in the past
☐ Have bleeding when you clean between your teeth
☐ Have gum recession or exposed root surfaces
☐ Notice bad breath or burning sensation
☐ Have any loose/drifting teeth, or areas that collect food when you eat
☐ None

If any responses need further clarification, please describe below:

_____
_____

Oral Cancer (select all that apply): *

☐ Smoke tobacco ☐ Chew tobacco ☐ Have any persistent sore spots in your mouth or lumps/bumps in your head
☐ Feel as if you have a lump in your throat ☐ Think you are at risk for HPV infection ☐ None

Red asterisk (*) signifies a required field.

If any responses need further clarification, please describe below:

_____

_____

Function/Bite/TMJ Dysfunction (select all that apply): *

☐ Missing teeth other than your wisdom teeth ☐ Experience discomfort when chewing ☐ Joints get stuck or locked
☐ Experience frequent headaches or jaw/facial pain ☐ Jaw joints click, pop, or make grinding sounds
☐ Clench/grind during sleep or daytime ☐ Treated for a jaw joint problem in the past (if yes, explain below)
☐ Wear removable dentures or partial dentures (if yes, are they comfortable/well-fitting?) ☐ None

If any responses need further clarification, please describe below:

_____

_____

Cardiovascular Health (select all that apply): *

☐ High blood pressure/Hypertension ☐ Heart disease ☐ Heart valve replacement ☐ Heart attack ☐ Stroke ☐ Stent
☐ Heart surgery ☐ Pacemaker ☐ Fainting/Dizziness ☐ High Cholesterol
☐ Experience shortness of breath of chest pain/angina ☐ Irregular Heart Beat (Arrythmia)/Heart Murmur ☐ None

If any responses need further clarification, please describe below:

_____

_____

Respiratory Disease (select all that apply): *

☐ Asthma ☐ COPD ☐ Emphysema ☐ Tuberculosis ☐ Allergies (seasonal) ☐ Sinus problems ☐ None

If any responses need further clarification, please describe below:

_____

_____

Brain Health (select all that apply): *

☐ Dementia ☐ Alzheimer's Disease ☐ Parkinson's Disease ☐ Depression ☐ Anxiety Disorder ☐ Seizure/Epilepsy
☐ Past brain/head trauma ☐ ADD/ADHD ☐ Mental Disorders ☐ Psychiatric Treatment
☐ Lost interest in activities that used to make you happy ☐ Experience "brain fog" where your awareness seems dulled
☐ Frequently forget where you put your keys or phone or how to get from place to place
☐ Have difficulty remembering names or words you want to use ☐ None

If any responses need further clarification, please describe below:

_____

_____

Diabetes (select all that apply): *

☐ Diabetes - ☐ Type 1 ☐ Type 2 ☐ Gums bleed when you brush or floss ☐ None

If any responses need further clarification, please describe below:

_____

_____

Blood Disorders (select all that apply): *

☐ AIDS/HIV ☐ Anemia ☐ Sickle Cell Disease ☐ Bruise Easily ☐ Excessive Bleeding ☐ None

If any responses need further clarification, please describe below:

_____

_____

Cancer (select all that apply): *

☐ Undergoing cancer treatment ☐ History of cancer ☐ History of radiation ☐ History of chemotherapy
☐ Have suspicion or fear of cancer in your body ☐ None

Have you ever taken Fosamax, Boniva, Actonel or any cancer medication containing Bisphosphonates? ◯ Yes ◯ No

If any responses need further clarification, please describe below:

_____

_____

Dependency/Addiction: *

☐ Currently in recovery or being treated for addiction ☐ Smoke tobacco ☐ Chew tobacco
☐ Want to quit using tobacco ☐ Drug/alcohol addiction ☐ Consume caffeine in excess of three 8-oz servings a day
☐ Depend on any prescription or non-prescription drugs to sleep, wake, or relieve pain ☐ Feel you're addicted to sugar
☐ None

If any responses need further clarification, please describe below:

_____

_____

Bone Health (select all that apply): *

☐ Osteopenia/Osteoporosis ☐ Abnormal bone density test ☐ Vitamin D/D3 Deficiency ☐ None

If any responses need further clarification, please describe below:

_____

_____

Joints (select all that apply): *

☐ Joint inflammation ☐ Joint pain ☐ Arthritis ☐ Gout ☐ Artificial joint ☐ None

If any responses need further clarification, please describe below:

_____

_____

Women's Health (select all that apply): *

☐ Pregnant/planning pregnancy/nursing ☐ Taking birth control ☐ None

If any responses need further clarification, please describe below:

_____

_____

Organ Dysfunction (select all that apply): *

☐ Thyroid disease ☐ Jaundice ☐ Hepatitis ☐ Liver Disease ☐ Kidney Disease ☐ Oral or injection steroids
☐ Stomach problems ☐ Glaucoma ☐ Rheumatic Fever ☐ STD ☐ None

If any responses need further clarification, please describe below:

_____

_____

Family History of Medical Conditions (please list conditions and relationship to family member):

_____

_____

Sleep (select all that apply): *

☐ You and your bed partner snore ☐ Experience interruptions in breathing during sleep ☐ Have difficulty sleeping
☐ Feel tired or fatigued during the day ☐ Completed a sleep study ☐ Use a CPAP or oral sleep appliance
☐ Remember dreaming ☐ None

If any responses need further clarification, please describe below:

_____

_____

Allergies, Food Sensitivities, and Other Chronic Inflammatory Conditions (select all that apply): *

☐ Irritable Bowel Syndrome (IBS) ☐ Fibromyalgia ☐ Chronic Fatigue Syndrome ☐ Insulin resistance
☐ Periodontal/gum disease ☐ Other chronic inflammatory conditions ☐ Food sensitivities to dairy, wheat, or soy
☐ Difficulty losing weight despite considerate effort ☐ Regularly eat foods that make you feel sluggish, sick, or guilty
☐ Have red, patchy, or itchy skin or itchy ears ☐ Follow a special diet ☐ Aspire to make changes to your diet
☐ Desire a change in weight ☐ None

If any responses need further clarification, please describe below:

_____

_____

What sugary foods or drinks do you consume regularly? (List *any* beverages you consume on a regular basis.)

_____

_____

_____

Do you exercise regularly? How many times per week? What do you currently do for exercise? Do you have exercise goals you hope to achieve?

_____

_____

_____

_____

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Any additional health issues/concerns not already addressed:

_____
_____
_____
_____
_____
_____
_____
_____
_____

☐ * I understand that responsibility for payment for services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered unless other financial arrangements have been made. I understand that this office will prepare any insurance claim forms, will assist in making collections from insurance companies, and will credit such collections to my account. I authorize insurance benefits to be paid directly to the doctor. I also understand that it is my responsibility to pay in full any balance due to an insurance claim over 75 days old. I understand that a 1.5% service charge (18% per annum) will be added to unpaid balances exceeding 90 days. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid at the time services are performed. I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of the patient examination.

☐ * I understand that our providers, Dr. Austin Green, D.D.S., Dr. Michelle Hinds, D.D.S., and Dr. Donna Miller, D.D.S., are listed as out-of-network providers with insurance companies.

☐ * By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will service as my electronic signature.

Name of Patient, Parent, or Guardian completing this form:

_____ **Date:** _____

Relationship to patient: *

◯ Self ◯ Parent ◯ Guardian ◯ Spouse ◯ Other