

# ***KIMBERLEY CAPUA DDS, PA***

## **GENERAL DENTISTRY**

3105 Old Denton Road  
 Carrollton, Texas 75007  
 (972) 418-1811

- FOR OFFICE USE ONLY -

DATE	PLAN TYPE	EXPIRATION DATE
PATIENT I.D. NUMBER		
_____		

LAST NAME	FIRST NAME	M.I.	NAME THAT YOU WISH TO BE CALLED			HOME PHONE ( )	BUS. PHONE ( )
SPOUSE'S NAME IN FULL				GUARDIAN'S NAME IN FULL		PATIENT'S CELL PHONE ( )	
HOME ADDRESS		CITY	STATE	ZIP CODE		EMAIL ADDRESS	
SOCIAL SECURITY NO.		DATE OF BIRTH	AGE	SEX	MARITAL STATUS		DRIVERS LICENSE NO.
PARENTS NAME - If 18 yrs. or younger		MOTHER'S WORK # ( )			INDIVIDUAL RESPONSIBLE FOR PAYMENT		
		FATHER'S WORK # ( )					
NAME OF INSURANCE COMPANY			INSURED'S SOCIAL SECURITY NO.			GROUP NO.	
PATIENT'S OR GUARDIANS EMPLOYMENT				OCCUPATION			
BUSINESS ADDRESS		CITY	STATE	ZIP CODE			
SPOUSE'S EMPLOYMENT			OCCUPATION			BUS. PHONE ( )	
REFERRED TO OFFICE BY			MEDICAL DOCTOR			MEDICAL DR. TELEPHONE NO. ( )	
PURPOSE OF VISIT			PREVIOUS D.D.S. AND THEIR TELEPHONE# ( )				
HAVE WE TREATED ANY OF YOUR FAMILY OR FRIENDS?				WHO?			
EMERGENCY CONTACT		TELEPHONE# ( )		NEAREST LIVING RELATIVE		TELEPHONE# ( )	

## **CONSENT FOR TREATMENT**

- I hereby authorize doctor or designed staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) \_\_\_\_\_'s dental needs.
- Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
- I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
- Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of services unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. In the event of default I promise to pay any legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to collect this note.

Patient \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Parent or Responsible Party \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

## Health History

Answers to the following questions are for our records only and will be considered confidential.

1. Date of last Physical Examination \_\_\_\_\_ Reason: \_\_\_\_\_
2. Date of last Dental Examination \_\_\_\_\_ Date of last Dental X-Rays \_\_\_\_\_
3. Date of last Dental Cleaning \_\_\_\_\_ Findings: \_\_\_\_\_

### CIRCLE

- YES NO 4. Are you having pain or discomfort at this time? Explain: \_\_\_\_\_
- YES NO 5. Do you feel very nervous about having dental treatment? \_\_\_\_\_
- YES NO 6. Are you happy with the color of your teeth? \_\_\_\_\_
- YES NO 7. Is there anything that you dislike about your smile? Explain: \_\_\_\_\_
- YES NO 8. Have you been a patient in the hospital during the past 5 years? Reason: \_\_\_\_\_
- YES NO 9. Have you been under the care of a medical doctor during the past two years? Reason: \_\_\_\_\_
- YES NO 10. Have you taken any medicines or drugs in the last two years? \_\_\_\_\_
- YES NO Are you currently taking any medications? \_\_\_\_\_
- YES NO Have you ever taken prescription Redux or Pondimin (Fen Phen)? \_\_\_\_\_
- YES NO 11. Are you Allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or other drugs, medications? \_\_\_\_\_
- YES NO Are you allergic to any form of metals (i.e., jewelry)? \_\_\_\_\_
- YES NO 12. Have you ever had any excessive bleeding requiring special treatment? \_\_\_\_\_
- YES NO Are you currently taking: Ginseng, Ginko Biloba, Garlic, Vit. E, Licorice of Sassafras Tea, or St. John's Wort? (circle)

### 13. Circle any of the following which you have had or have at present:

- |                           |                              |   |   |
|---------------------------|------------------------------|---|---|
| Heart Failure             | Ulcers                       | Glaucoma  | *Any Type of Implant<br>(Heart Valve, etc.) |
| Heart Disease or Attack   | Mental Retardation           | Pain in Jaw Joints                                | Psychiatric Treatment                       |
| Chest Pains               | Emphysema                    | Birth Defects                                     | Sickle Cell Disease                         |
| High Blood Pressure       | Cough                        | HIV Positive, ARC AIDS                            | Bruise Easily                               |
| * Mitral Valve Prolapse   | Tuberculosis (TB)            | Hepatitis: (type: _____)<br>(Yr. occurred: _____) | *Artificial Hip, Knee or<br>other Joint     |
| *Heart Murmur             | Asthma                       | Liver Diseases                                    | Latex Sensitivity                           |
| *Rheumatic Fever          | Hay Fever                    | Jaundice  | Tumors (type: _____)<br>(location: _____)   |
| *Congenital Heart Lesions | Sinus Trouble                | Blood Transfusion                                 | Neurological Disorders                      |
| Use of Tobacco Products   | Allergies or Hives           | Drug Addiction                                    | Nervous/Anxious Disorders                   |
| Thyroid Disease           | Diabetes                     | Hemophilia  |   |
| Heart Pacemaker           | Sexually Transmitted Disease | *Any Type of Transplant                           |   |
| Heart Surgery             | Radiation Therapy            | Cold Sores  |   |
| Cancer (type: _____)      | Chemotherapy                 | Fever Blisters                                    |   |
| Anemia                    | Arthritis                    | Epilepsy or Seizures                              |   |
| Stroke                    | Alcoholism                   | Fainting or Dizzy Spells                          |   |
| Kidney Trouble            | Cortisone Medicine           |   |   |

*\*Antibiotic premedication may be required prior to your appointment.*

### CIRCLE

- YES NO 14. Have you ever had any instructions in oral hygiene? \_\_\_\_\_
- YES NO 15. Are there now any growths of sores in or around your mouth? \_\_\_\_\_
- YES NO 16. Do you have any trouble chewing? \_\_\_\_\_
- YES NO 17. Does food catch between your teeth? \_\_\_\_\_
- YES NO 18. Do you have pain in or near your ears? \_\_\_\_\_
- YES NO 19. Do you habitually clench or grind your teeth during the day or night? \_\_\_\_\_
- YES NO 20. Have you ever been told that you have gum problems? \_\_\_\_\_
- YES NO 21. Do you now have bleeding gums or any other gum conditions? \_\_\_\_\_
- YES NO 22. WOMEN: Are you pregnant now? \_\_\_\_\_
- YES NO 23. I understand that antibiotics, if prescribed, may reduce the effectiveness of birth control pills and an alternate method should be used. \_\_\_\_\_
- YES NO 24. Is there anything related to your medical or dental history that you have not indicated above?  
If yes, Explain: \_\_\_\_\_

Patient/Parent/Guardian Signature \_\_\_\_\_ DATE \_\_\_\_\_