Shirley E. Mathew, DDS, FAGD

(Fellow of the Academy of General Dentistry)

Creekview Family Dentistry

We are on the internet. ***www.dentaloffice.com***

860 Hebron Parkway, Suite 902, Lewisville TX 75057 972-459-1100

Adult Medical / Dental History

Date:______________________

Patient's First Name______________________ **Middle Initial** ___ **Last Name** ______________**Nickname**__________

Why did you come to the dentist today? ____

Address__________________________________ **City**____________ **Zip**_____________

Patient's Home # _______________ **Work #** ________________ **Pager/ Cell Tel #**_________________

Date of Birth____/_____/_____ **Sex: M (__) F (__) Marital Status:Single (__) Married(__) Widwed(__)Divorced(__)**

Social Security Number:______— ______— ________ **E mail Address (if any)** __________________________

Occupation________________________________**Employer**____

Do you have any children? Yes (__) or No (__) Names and Ages of your children

1) ______________ **2)** ________________ **3)** _______________ **4)** _______________**5)** _____________

In case of an emergency, whom should be notified?______________________________**Tel.#**______________

Name of Spouse(if applicable) _______________________**Spouse Work Phone/Cellular:**_________________

Occupation of Spouse _____________________________ **Employer** _______________________________

Spouse's Date of Birth____/____/_____ **Spouse's Social Security Number** _______— _____—_________

Person responsible for account (if not yourself) ____

Whom may we thank for referring you ? Walk-in (___) Sign-Location (___) Internet (___) Google (___)

AT&T Yellow Pages (___) Verizon Yellow Pages (___) Your Town Yellow Pages (___) Other Yellow Pages (___)

Val Pak Mail (___) Money Mailer (___) Letter (___) Newsletter (___) Flyer with our Staff Picture (___)

Friend/ Family/ Employee (Name: ___________________________**) Other** ____________________

Do you have dental insurance that may cover any part of our professional services? Yes (___) No(___)

Dr. Mathew does not participate in any of the managed care dental plans. Insurance is accepted and submitted on your behalf, but you are responsible for any charges your insurance does not cover, at the time of service.

INSURANCE INFORMATION

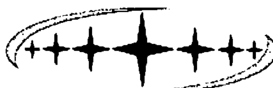
Primary Insured Party's Full Name___________________________**Social Security Number**__________________

Relationship to Patient: Self (___) Spouse (__) Parent / Step Parent (__) Other (specify :_______________**)**

Employer ____________________________ **Insurance Company Name**______________________________

Ins. Address ____ **Ins Phone #**_______________

Group Number ________________________ **Subscriber ID** ___________________________



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Physician's Name ______________________ City ____________ Phone: __________
Former Dentist's Name ______________________ City ____________ Phone: __________
Why are you changing dentists?

____

____

When was the last time you had a check up and professional cleaning? __________ xrays? __________
Xrays that were taken at your last visit? FMX 18 xrays (__) BWX 4 xrays (__) Panorex 1 large xray (__)
Are you having pain today? Y (__) N (__) Please describe: ______________________
Are you apprehensive about dental treatment Y (__) N (__) If you are apprehensive, what of ? (be very specific)

____

Have you been told to take an antibiotic before dental treatment? Y(__) N (__) What antibiotic __________
Have you had braces? Y(__) N (__) Have you had your teeth bleached or whitened? Y(__) N(__)
Are you happy with your smile? Y(__) N(__) If not, what would you change?______________
Do you smoke? Y(__) N(__) Have you ever been told you have periodontal disease Y(__) N(__)
Do your gums bleed when you brush Y(__) N(__) Bleed when you floss? Y (__) N (__)
Do you have pain or clicking when you open and close your mouth? Y(__) N(__)
Have you ever had any serious problems with previous dental work Y(__) N(__) Describe: __________
Have you ever had any of the following diseases or medical problems? **Please Check.**

(__) ADD/ ADHD
(__) Allergies or Hives
(__) Anemia
(__) Angina Pectoris (chest pain)
(__) Arthritis
(__) Artificial bone /valve /joint
(__) Asthma
(__) Blood transfusion
(__) Bruise Easily
(__) Bulimia
(__) Cancer (what kind?)__________
(__) Cerebral Palsy
(__) Chemotherapy
(__) Cold Sores or Fever Blisters
(__) Congenital Defect
(__) Congenital Heart Defect / Lesions
(__) Cortisone (steroid) medicine
(__) Diabetes
(__) Drug Addiction
(__) Drug/Alcohol abuse
(__) Emphysema
(__) Epilepsy or seizures
(__) Fainting or Dizzy Spells
(__) Fever blisters
(__) Genital Herpes
(__) Glaucoma
(__) Growth Disorder
(__) Handicaps/ Disabilities
(__) Hay Fever
(__) Heart Pace Maker
(__) Hearing Impairment
(__) Heart Disease / Attack
(__) Heart Murmur
(__) Heart Surgery
(__) Hemophilia
(__) Hepatitis
(__) High Blood Pressure
(__) HIV + / AIDS / ARC
(__) Kidney Trouble
(__) Liver Disease
(__) Mental Retardation
(__) Mitral valve prolapse
(__) Nervousness
(__) Pain in Jaw Joints
(__) Psychiatric Treatment
(__) Radiation Treatment
(__) Rheumatic Fever
(__) Rheumatism
(__) Scarlet Fever
(__) Shortness of Breath
(__) Sickle Cell Disease
(__) Sinus Trouble
(__) Stroke
(__) Thyroid Disease
(__) Tourette Syndrome
(__) Tuberculosis (TB)
(__) Ulcers
(__) Venereal Disease (Syphilis, Gonorrhea)
(__) Yellow Jaundice
(__) Any operations? (What?)
____

If you allergic to any of the following, please check.

(__) Codeine (__) Dental Anesthetics (__) Penicillin (__) Erythromycin (__) Clindamycin (__) Latex

Please list any other drugs that you are allergic to:

____

Please list all medications/herbs/over the counter drugs you are taking and why you are taking them.
1)__________ for __________ 2)__________ for __________

3) __________ for __________ 4)__________ for __________

5) __________ for __________ 6)__________ for __________
Please list any other medical condition/ congenital abnormalities that you have been or are being treated for:

____

Are you pregnant Y (__) N (__) Possibly (__) Are you nursing a baby? Y (__) N (__)

I affirm that the information given today is correct to the best of myknowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical history. I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistant that she deems fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor and / or her staff. I authorize this office to use this signature on all insurance claims.
I agree to pay all services rendered by this office regardless of the insurance benefits.

Signature of patient: ______________________ Date : __________