4450 East Highway 287
Midlothian, Texas 76065
972-723-2300

CLARK DENTAL GROUP
www.brianclarkdds.com

211 West Belt Line Road
Cedar Hill, Texas 75104
972-291-4281

To help us meet all your dental needs, please fill out this form completely in ink.
If you have any questions, please ask and we will be happy to assist you.

Patient Information (Confidential)

Name_____ Preferred Name _____Date_____

Soc Sec # _____ Birthdate _____ Email_____

Address _____City_____St_____Zip_____

Home Phone _____ Cell _____ Gender: □ Male □ Female

Check Appropriate Box: □ Child □ Single □ Married □Separated □ Divorced □ Widowed

Patient's/ Parent's Employer _____ Work Phone _____

Business Address_____City_____St_____Zip_____

Spouse/ Parent's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to Contact in Case of Emergency? _____ Phone _____

What is the reason for your dental visit today? _____

Responsible Party

Name of Person Responsible for this Account _____

Soc Sec # _____ Birthdate _____ Email_____

Address _____City_____St_____Zip_____

Home Phone _____ Cell _____ Driver's License # _____

Is this person currently a patient in our office? □ Yes □ No

For your conveniece, we offer the following methods of payment. Please check the option you prefer.

Payment is due in full at each appointment. □ Cash □ Check □ Credit Card □ Care Credit

Insurance Information

Insured's Name _____ Insured's Soc Sec # _____

Insurance Company _____ ID # _____ Group # _____

Insurance Co Address _____

Insurance Co. Phone # _____ Insured's Employer _____

As of April 14, 2003, Federal law requires us to offer our patients a copy of our Notice of Privacy Practices.
I have been offered a copy from this office of the Notice of Privacy Practices:

Date _____ Signature _____

Patient Medical History

Physician_____ Office Phone_____ Date of Last Exam_____

Any changes in general health in the past year	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you been hospitalized for any surgical operation or serious illness within the last 5 years? If Yes, Please Explain_____	☐	☐
3. Are you taking any medications(s) including non-prescription medicine? If Yes, what medication(s) are you taking?	☐	☐
4. Do you require antibiotics before dental treatment?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Do you have or have you had any of the following?		

	Yes	No
8. Are you allergic to or have you had any reaction to the following?	☐	☐
Local Anesthetics (e.g. Novacain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc)	☐	☐
Latex Rubber	☐	☐
Other_____	☐	☐
9. Do you have a persistent cough or throat clearing not associated with a knowm illness (lasting more than 3 weeks)?	☐	☐
10. Women Only:		
Are you pregnant or think you may be?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

	Yes	No
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Rheumatic Fever	☐	☐
Swollen Ankles	☐	☐
Fainting/Seizures	☐	☐
Asthma	☐	☐
Low Blood Pressure	☐	☐
Epilepsy/Convulsions	☐	☐
Leukemia	☐	☐
Diabetes	☐	☐
Kidney Diseases	☐	☐
AIDS or HIV Infection	☐	☐
Thyroid Problem	☐	☐

	Yes	No
Heart Disease	☐	☐
Cardiac Pacemaker	☐	☐
Heart Murmur	☐	☐
Angina	☐	☐
Frequently Tired	☐	☐
Anemia Radiation	☐	☐
Emphysema	☐	☐
Cancer	☐	☐
Arthritis	☐	☐
Joint Replacement or Implant	☐	☐
Hepatitis/Jaundice	☐	☐
Sexually Transmitted Disease	☐	☐
Stomach Troubles/Ulcers	☐	☐

	Yes	No
Chest Pains	☐	☐
Easily Winded	☐	☐
Stroke	☐	☐
Hay Fever/Allergies	☐	☐
Tuberculosis	☐	☐
Therapy	☐	☐
Glaucoma	☐	☐
Recent Weight Loss	☐	☐
Liver Disease	☐	☐
Heart Trouble	☐	☐
Respiratory Problems	☐	☐
Mitral Valve Prolapse	☐	☐
Other_____	☐	☐

Patient Dental History

Name of Previous Dentist & Location_____ Date of Last Exam_____

	Yes	No
1. Do you like your smile?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck, or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you had any orthodontic treatment?	☐	☐
12. Have you ever had any past difficult extractions?	☐	☐
13. Have you ever had any prolonged bleeding following extractions?	☐	☐
14. Do you wear partials or dentures or implants If yes, date of placement_____	☐	☐
15. Do your gums bleed while brushing or flossing?	☐	☐
16. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release my information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I will be responsible for payment of all services rendered on my behalf or my dependents. I agree to pay the $25 missed appointment/no show fee should I fail to provide notice of cancellation 24-hours in advance of scheduled appointments.

X _____

Signature of patient (or parent/guardian if minor)