**Health History**

**Patient Name:**_____
**Physician's Name:**_____ **Date of last Physical Exam:**_____
**In case of Emergency, notify:**_____**Phone:**_____
**Nearest Relative:**_____**Phone:**_____
**Address:**_____**City:**_____**State:**_____**Zip:**_____
**Do you have or have had any of the following? Please Circle Yes or No**

| | | | | | |
|---|---|---|---|---|---|
| Hypoglycemia, Diabetes | Yes/No | Aids Exposure | Yes/No | Heart Attack, Heart Trouble | Yes/No |
| Circulatory Problems | Yes/No | Hay Fever, Asthma | Yes/ No | Mitral Valve Prolapse | Yes/No |
| Excessive Bleeding | Yes/No | Epilepsy, Seizers | Yes/No | Artificial Heart Valves | Yes/No |
| Anemia, Blood Disorder | Yes/No | Hepatitis, Jaundice | Yes/No | Heart Murmur | Yes/No |
| Lung Problems | Yes/No | Fainting, Blackouts | Yes/No | Artificial Joints | Yes/No |
| Nervous Disorder | Yes/No | Blood Transfusion | Yes/No | High Blood Pressure | Yes/No |
| Facial or Head Injuries | Yes/No | Kidney Problems | Yes/No | Rheumatic Fever | Yes/No |
| Glaucoma, Eye Problems | Yes/No | Malignancies, Cancer | Yes/No | Ulcer, Digestive Problems | Yes/No |
| Sinus Problems | Yes/No | Are you Pregnant? | Yes/No | Stroke | Yes/No |
| Headaches, Migraines | Yes/No | Radiation Treatment | Yes/No | Thyroid Problems | Yes/No |
| Heart Pacemaker | Yes/No | Other | Yes/No | Drug Use | Yes/No |

**Have you been hospitalized in the last 2 years?**_____ **If yes please Explain**_____
_____
**Have you have unfavorable reactions to any of the following. Please circle Yes or No**

| | | | | | |
|---|---|---|---|---|---|
| Aspirin: | Yes/No | Codeine: | Yes/No | Anesthetics: | Yes/No |
| Novocaine: | Yes/No | Sedatives: | Yes/No | Sulfa: | Yes/No |
| Penicillin: | Yes/No | Other: | Yes/No | | |

**Please list any medications you are currently taking:**_____
_____
**Date of last dental visit** _____**Date of last cleaning** _____**Date of last set of full x-rays** _____
**Name of last Dentist** _____**Phone** _____**May we have records released Yes/No**
**How often do you brush?**_____ **How often do you floss?**_____
**Do you smoke/Chew tobacco? Yes/No how often** _____**Do You Drink alcohol? Yes/No How often**_____
**Do you Snore? Yes/No**
**Have you noticed any of the following? Please Circle Yes or No**

| | | | | | |
|---|---|---|---|---|---|
| Loss of teeth? | Yes/No | Teeth tender to chew on? | Yes/No | Discomfort in face, head or neck? | Yes/No |
| Bleeding Gums? | Yes/No | Food caught between teeth? | Yes/No | Sensitivity to sweets? | Yes/No |
| Grinding teeth? | Yes/No | Hot and cold sensitivity? | Yes/No | Jaw clicking or popping? | Yes/No |
| Sores in mouth? | Yes/No | Swelling, or lumps in mouth? | Yes/No | Do you clench your teeth? | Yes/No |

**Have you ever had periodontal treatment (deep cleaning)? Yes/No If yes how long ago?**_____
**Have you ever had any problems with dental treatment? Yes/No If yes, How long ago?**_____

**The Information above is correct to the best of my knowledge. I give consent to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. I also authorize the doctor and her staff to perform dental treatment indicated by the diagnosis.**

_____ _____
**Signature of Patient or Parent/ Guardian** **Date**

_____ _____
**Anita Paulus, D.D.S., P.C. (Dentist)** **Date**

**Blood pressure**_____**Pulse**_____**Date**_____**Initials**_____
**Oral Cancer Screen Date** _____**Initials**_____
**ASA Classification** _____**Date**_____**Initials**_____

ANITA M. PAULUS, D.D.S., P.C.
FAMILY & COSMETIC DENTISTRY

# *Assignment of Insurance Benefits to Dentist*

I agree to assign benefits from my insurance company to Anita M. Paulus, D.D.S., P.C. in the course of dental treatment in her office. The treatment and financial plans have been explained and presented to me and the insurance company's portion has been estimated. I understand that after the insurance company has paid their portion to the doctor, the remaining amount (known as the co-payment) is due and payable to Anita M. Paulus, D.D.S., P.C. I agree to assign benefits to Anita M. Paulus, D.D.S., P.C. from the date of signature below indefinitely.

Patient Name_____ Date_____

Patient Signature_____ Date_____

Responsible Party Signature_____ Date_____

Dentist Signature_____ Date_____

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You may refuse to sign this acknowledgement*

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Please Print Name Signature Date

With whom may we discuss treatment? _____

## Method of Contact

Our office sends reminder cards, makes phone calls, sends emails and text messages and leaves messages for appointments. We will also talk to necessary doctors and dentists about your treatment. I understand this method of communication and consent to it.

Please Sign_____ Date_____

4901 BYERS
FORT WORTH, TEXAS 76107
817-738-2163