WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

JOHN S. RUBIN, D.D.S., P.A. **2600 West 7th Street, Suite 184, Ft Worth, TX 76107** **(817) 332-5192**

WWW.JOHNRUBINDDS.COM

About You

Today's Date: _____ E-mail Address: _____

Name: _____ I prefer to be called: _____
Last First Mi Mr Mrs Ms Dr

Responsible Party: _____
Last First Mi Mr Mrs Ms Dr

Birthdate: ___/___/___ Age: _____ Social Security #: _____ ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Address: _____
Street City State Zip

Home Phone #:(_____)_____ Work Phone #:(_____)_____ Ext: ____ Cell #:(_____)_____

Driver's License #: _____ Whom may we thank for referring you? _____

Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street/PO Box City State Zip

Emergency Information

His / Her Name: _____ Relation: _____ Work Phone #: (_____)_____ Home Phone #: (_____)_____

Address: _____
Street City State Zip

Spouse Information

His / Her Name: _____ Birthdate: ___/___/___ Social Security #: _____

Employer: _____ Work Phone #: (_____)_____ Ext: _____ Driver's License #: _____

Dental Insurance Information

Primary Insurance

Insurance Co. Name: _____ Phone #: (_____)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____

CONTINUED ON BACK

Medical History

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____

Phone #: (____) _____ Date of last visit: _____

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: _____

Are you taking any prescription / over-the-counter drugs? ❑ Yes ❑ No

Please list each one: _____

_____

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No When due: _____

NOTE: Oral antibiotics may interfere with the effectiveness of oral contraceptives. Please consult with your physician.

Do you snore at night? ❑ Yes ❑ No

Do you stop breathing at night? ❑ Yes ❑ No

Have you ever had any of the following diseases or medical problems

Y N Abnormal Bleeding
Y N Alcohol / Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial / Joints / Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer / Chemotherapy
Y N Chest Pain
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Epilepsy
Y N Excessive Bleeding
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack / Surgery
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis, Any Form
Y N Herpes / Fever Blisters
Y N High Blood Pressure
Y N HIV / AIDS
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic / Scarlet Fever
Y N Seizures
Y N Sickle Cell Disease / Traits
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Jewelry/Metals
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Other

Please list any other drugs/materials that you are allergic to: _____

_____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

_____ _____

Signature Date

Dental History

Why have you come to the dentist today? _____

_____

Are you currently in pain? ❑ Yes ❑ No

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Previous dentist: _____ Last visit: _____

Last cleaning date: _____ Last x-ray date: _____

Why did you leave your previous dentist? _____

_____

What did you like most & least about any dentist you have seen?

_____

_____

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Have you ever had a serious / difficult problem associated with any previous dental work? ❑ Yes ❑ No

How often do you brush? _____ times per day Floss? _____ times per day

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Are your teeth sensitive to heat, cold, or anything else? _____

Do you have loosening of teeth? ❑ Yes ❑ No

Do you still have wisdom teeth? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No

Have you ever had periodontal disease? ❑ Yes ❑ No

Have you ever had gum treatments? ❑ Yes ❑ No

Does food catch between your teeth? ❑ Yes ❑ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Do you clench or grind your teeth? ❑ Yes ❑ No

Do you have clicking or popping of your jaws? ❑ Yes ❑ No

Would you like fresher breath? ❑ Yes ❑ No

Whiter teeth? ❑ Yes ❑ No

Are you happy with the way your smile looks? ❑ Yes ❑ No

If not, what would you change? _____

_____

Have you ever tried Nitrous Oxide (relaxing gas)? ❑ Yes ❑ No

Responsibility for payment of Dental Services provided in this office is that of the patient or responsible party, due and payable at the time services are rendered. I certify that if I am covered by dental insurance, I assign directly to Dr. John S. Rubin all insurance benefits otherwise payable to me. I also understand that if after two months (60 days) my insurance company has not paid the claim or if there is an outstanding balance still due after insurance, payment becomes my responsibility. I authorize the use of this signature on all my insurance submissions to secure the payment of benefits. A 1.50% finance charge (18%) annually will be added to any balance over 60 days due.

_____ _____

Signature Date