

# Michael E. Harris, D.D.S.

1109 South 31<sup>st</sup> Street, Temple, TX 76504

*Welcome to our office! So that we may provide you with the best possible care, please complete both sides of this form thoroughly. All information will remain confidential.*

Patient Name \_\_\_\_\_  
Last First Middle Initial Preferred Nickname

Address \_\_\_\_\_  
Street City State Zip

|                   |  |                   |                |
|-------------------|--|-------------------|----------------|
| Date of Birth     | ( ) Male ( ) Female ( ) Single ( ) Married |                   |                |
| Social Security # | Driver's License #                         | State             |                |
| Home Phone<br>( ) | Work Phone<br>( )                          | Cell Phone<br>( ) | e-mail address |
| Occupation        | Employer                                   |                   |                |

|                        |                   |
|------------------------|-------------------|
| Spouse's Name          | Social Security # |
| Spouse's Date of Birth | Work Phone ( )    |
| Employer               | Occupation        |

Person responsible for payment: ( ) Self ( ) Spouse ( ) Parent/Guardian ( ) Other  
If responsible party is not yourself or your spouse, please complete this section:  
Name \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_  
Address, including street, city, state and zip: \_\_\_\_\_

|                         |                                    |
|-------------------------|------------------------------------|
| <b>DENTAL INSURANCE</b> |                                    |
| Insurance Company Name  | Group #                            |
| Insured's Name          | Employee # (if different than SS#) |

**Please read, and then initial.**  
Your dental insurance policy is an arrangement between the insurance carrier and you. Our office is happy to prepare claim forms to assist you in making collection from the insurance carrier. Any amount authorized to be paid directly to the dentist will be credited to your account upon receipt. Payment of your account is your responsibility, and you will be asked to pay in full for balances or uncovered procedures.  
\_\_\_\_\_ Initial here to signify understanding and agreement

Whom can we thank for referring you? \_\_\_\_\_

Have you received dental services from Dr. Harris before? ( ) No ( ) Yes; When? \_\_\_\_\_

Is an immediate family member a patient here? ( ) No ( ) Yes; Who? \_\_\_\_\_

|                                     |           |
|-------------------------------------|-----------|
| Contact in case of emergency: Name: |           |
| Relationship to Patient             | Phone ( ) |

## MEDICAL HEALTH HISTORY

Please indicate which of the following you have had, or have at present:

|   |   |  |
|---|---|--|
| <input type="checkbox"/> Chest pain/angina            | <input type="checkbox"/> Ulcers             | <input type="checkbox"/> Hepatitis - Type _____    |
| <input type="checkbox"/> Congenital heart disease     | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Venereal disease          |
| <input type="checkbox"/> Heart murmur                 | <input type="checkbox"/> Thyroid problems   | <input type="checkbox"/> AIDS                      |
| <input type="checkbox"/> High blood pressure          | <input type="checkbox"/> Glaucoma           | <input type="checkbox"/> HIV positive              |
| <input type="checkbox"/> Mitral valve prolapse        | <input type="checkbox"/> Contact lenses     | <input type="checkbox"/> Blood transfusion         |
| <input type="checkbox"/> Artificial heart valve       | <input type="checkbox"/> Emphysema          | <input type="checkbox"/> Hemophilia                |
| <input type="checkbox"/> Heart pacemaker              | <input type="checkbox"/> Chronic cough      | <input type="checkbox"/> Sickle cell trait/anemia  |
| <input type="checkbox"/> Arthritis/Rheumatic fever    | <input type="checkbox"/> Tuberculosis       | <input type="checkbox"/> Cold sores/Fever blisters |
| <input type="checkbox"/> Cortisone medication         | <input type="checkbox"/> Asthma             | <input type="checkbox"/> Bruise easily             |
| <input type="checkbox"/> Swollen ankles               | <input type="checkbox"/> Hay fever          | <input type="checkbox"/> Liver disease             |
| <input type="checkbox"/> Stroke                       | <input type="checkbox"/> Latex sensitivity  | <input type="checkbox"/> Yellow jaundice           |
| <input type="checkbox"/> Artificial joints (hip/knee) | <input type="checkbox"/> Allergies or hives | <input type="checkbox"/> Neurological disorders    |
| <input type="checkbox"/> Kidney trouble               | <input type="checkbox"/> Sinus trouble      | <input type="checkbox"/> Epilepsy or seizures      |
| <input type="checkbox"/> Heart attack/disease/surgery | <input type="checkbox"/> Radiation therapy  | <input type="checkbox"/> Fainting or dizzy spells  |
| <input type="checkbox"/> Special/restricted diet      | <input type="checkbox"/> Chemotherapy       | <input type="checkbox"/> Nervous/Anxiety disorder  |
| <input type="checkbox"/> Tumors                       | <input type="checkbox"/> Psychiatric care   | <input type="checkbox"/> Smoker, how long? _____   |

Date of Last Medical Examination \_\_\_\_\_ Are you currently under a physicians care?  NO  YES Name of Physician \_\_\_\_\_ Reason for medical treatment: \_\_\_\_\_  
 Dr.'s Phone Number: \_\_\_\_\_

Are you taking any medications, drugs or vitamin/food supplements?  NO  YES If yes, what?

Have you been seriously ill or hospitalized during the past five years?  NO  YES

If yes, why? \_\_\_\_\_

Are you aware of having allergic or adverse reactions to any medications, substances, or metals?  NO  YES

(Circle) Penicillin? Codeine? If other, what? \_\_\_\_\_

Do you have any problem, disease or condition not listed above?  NO  YES; If Yes, describe: \_\_\_\_\_

Have you lost or gained 10 or more pounds in the last year?  NO  YES; Reason \_\_\_\_\_

Female patients: Are you pregnant?  YES ( Months \_\_\_\_\_ )  NO Nursing a baby?  YES  NO

Date of Last Dental Visit/ Exam \_\_\_\_\_ Name of Dentist \_\_\_\_\_

What is Your Present Dental Problem or Concern? \_\_\_\_\_

Do you like the color, size, and shape of your teeth?  NO  YES

If no, why not? \_\_\_\_\_

**Have you ever experienced any of the following?**

Bleeding gums .....  NO  YES

Bad Breath or bad taste .....  NO  YES

Pain or soreness .....  NO  YES

Food packing between teeth ...  NO  YES

Receding gums .....  NO  YES

Grinding your teeth .....  NO  YES

Loose teeth .....  NO  YES

Problem with snoring .....  NO  YES

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## CONSENT FOR TREATMENT

I understand the information on these forms is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. If further information is needed, you have my permission to ask the respective health care provider or agency, which may release such information to you. I will notify Dr. Harris of any changes in my health or medication. I give authorization to take x-rays, study models, photographs, or any other diagnostic aids needed to make a thorough diagnosis of my dental needs, or the minor patients needs. I give authorization for Dr. Harris to perform any and all forms of treatment, medication and therapy that may be indicated in treatment of said patient. I further give authorization to choose and employ such assistance as deemed fit.

I give my consent for photographs to be taken for teaching and presentation purposes. \_\_\_\_\_ (please initial)

As long as I am a patient of record, any of my records may be shared with other doctors for consultation and/or referral. \_\_\_\_\_ (please initial)

I understand responsibility for payment of dental services provided in this office for myself and my dependents is mine, due and payable at the time services are rendered unless other financial arrangements have been *previously* made.

PATIENT (or Guardian) Signature \_\_\_\_\_ Date \_\_\_\_\_

Dentist Signature \_\_\_\_\_ Date \_\_\_\_\_