J. Robert Donnelly, D.D.S

Master of Academy of General Dentistry

PATIENT INFORMATION Today's Date: _______________

Last Name: ____________________ First Name: ______________________ Preferred Name: __________________

D.O.B: _ _/_ _ / ____ Social Security #: _______-_____-__________ Drivers License #: ________________________

Address: ___________________________ Apt : _________ City:__________________ State: _______ Zip: ______

Home Phone: (___)_____________ Cell Phone (___)_____________ Work (___) __________________

E-mail: _______________________ Sex (Circle One): M F

Patient Employer/School: _______________________________ **Circle One:** Married/Widowed/Single/Minor

Spouse's Name:____________________ Spouse's D.O.B: __/__/_ _ ____ Spouse's Employer: __________________

Spouse's Cell # (____)_______________ Spouse's Work #: (____) ______________

FOR ALL STUDENTS & CHILDREN

Father's Name: _____________________ SS #: _____-____-________ DOB: ___/___/_____
Address: __________________________ Apt : ______ City:__________ State: _______ Zip: ______
Home #: (____) ____________ Cell # (___)__________ Work # (____) _____________ Employer: _________________
Email:___________________________

Mother's Name: _____________________ SS #: _____-____-________ DOB: ___/___/_____
Address: __________________________ Apt : ______ City:__________ State: _______ Zip: ______
Home #: (____) ____________ Cell # (___)__________ Work # (____) _____________ Employer: _________________
Email:___________________________

IN CASE OF EMERGENCY (Specify someone who does not live in your household)
Name: ___________________________________ Relationship ______________________
Home Phone: (_ _ _) _________________ Work Phone (_ __) ______________ Cell Phone (_ _ _) _______________

Whom may we thank for referring you to our practice? (Please circle referral source)

Community Impact Billboard/Sign Phone Book Wimberley Views and News
Online Reviews Internet Texas Monthly Friend/Relative: __________________
Newspaper Texas State Univ. Clinic Mailer Other: ___________________________

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health conditions that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions completely and truthfully.

Please explain any 'yes' answers on the lines provided.

Are you under a physician's care now? YES NO ____

Have you ever been hospitalized or had a major surgery? YES NO ____
____

Do you have any artificial joints? YES NO ____

Have you ever been told that you need antibiotics prior to dental treatment? YES NO ____
____

Have you ever had a serious head or neck injury?	YES	NO	____________________
Are you taking any medications, pills, drugs, vitamins, or herbal supplements?	YES	NO	____________________
Are you currently or have you ever taken any bisphosphonate therapy medication such as Fosamax, Actonel, or Boniva	YES	NO	If yes, which medication?__________ When and for how long? __________
Are you on a special diet?	YES	NO	____________________
Do you use tobacco?	YES	NO	What type and how often?__________
Do you use controlled substances?	YES	NO	____________________

WOMEN:	Are you pregnant or trying to get pregnant?	YES	NO
	Are you taking oral contraceptives?	YES	NO
	Are you nursing?	YES	NO

Please circle any of the following you are allergic to.

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other

Please list all medications you are allergic to ______________________________

____

Do you have, or have had, any of the following? (Please circle all that apply)

Abnormal bleeding	**Cancer**	**Heart attack/failure**	**Parathyroid disease**
AIDS/HIV	**Chemotherapy**	**Heart murmur**	**Psychiatric problems**
Alzheimer's Disease	**Chest pains**	**Heart pace maker**	**Radiation treatments**
Anaphylaxis	**Cold sores/fever blisters**	**Heart trouble/disease**	**Rheumatic fever**
Anemia	**Congenital heart disorder**	**Hemophilia**	**Sinus trouble**
Angina	**Convulsions**	**Hepatitis A, B, or C**	**Spina bifida**
Arthritis/gout	**Cortisone medicine/steroids**	**High blood pressure**	**Stomach/intestinal disease**
Artificial heart valve	**Diabetes**	**Hypoglycemia**	**Stroke**
Artificial joint	**Drug/alcohol abuse**	**Irregular heartbeat**	**Swelling of limbs**
Asthma	**Emphysema**	**Jaundice**	**Thyroid disease**
Blood disease	**Epilepsy or seizures**	**Kidney problems**	**Tonsillitis**
Blood transfusion	**Fainting spells/dizziness**	**Liver disease**	**Tuberculosis**
Breathing problems	**Frequent cough**	**Low blood pressure**	**Ulcers**
Bruise easily	**Glaucoma**	**Mitral valve prolapse**	

Any other serious medical conditions: ______________________________

DENTAL HISTORY

Reason for today's visit: ____________________
Previous Dentist & Last Visit (Optional): ____________________
How often do you floss? ____________ How often do you brush? ____________
Dental Anxiety 0 (None) ←→ 10 (high anxiety): ____________
Past Dental Experience (Please circle one): Excellent Positive Neutral Negative Awful
Have you had any problems with any previous dental treatment? YES NO
If yes, please explain: ____________________

Please circle all that apply:

Bad breath	Finger biting	Orthodontic treatment
Bleeding gums	Food collection between teeth	Periodontal treatment
Blisters on lips or mouth	Grinding teeth	Sensitivity to cold
Burning sensation on tongue	Gums swollen or tender	Sensitivity to hot
Chew on one side of mouth	Lip or cheek biting	Sensitivity to sweets
Cigarette, pipe or cigar smoking	Loose teeth or broken fillings	Sensitivity when biting
Clicking or popping jaw	Mouth breathing	Sores or growths in your mouth
Dry Mouth	Mouth pain, brushing	

Please circle 'YES' or 'NO' to indicate if you have had any of the following:

Do you have frequent headaches, neck aches, or shoulder aches?	YES	NO
Do you clench or grind your teeth?	YES	NO
Have you experienced any pain or soreness in the muscles of your face or around your ear or jaw?	YES	NO
Have you ever been diagnosed or treated for TMJ/TMD?	YES	NO
Are you interested in straightening your teeth?	YES	NO
Are you interested in whitening your teeth?	YES	NO
Do you have any missing or extra permanent teeth?	YES	NO
Do you snore when you sleep?	YES	NO
Do you have sleep apnea?	YES	NO
Do any of your teeth hurt?	YES	NO

If yes, please explain: ____________________
Is there anything about your teeth or smile that you would like to change? If so, please explain: ____________________
____
Is there anything you would like Dr. Donnelly to know? ____________________
____

Please list any individuals you would allow us to release your dental/personal history with if they were to call or come into the office requesting information, i.e. parent, spouse or family member.

Name: ____________________ Relation to patient: ____________________
Name: ____________________ Relation to patient: ____________________

I acknowledge that the above information is truthful and correct to the best of my knowledge. I understand that if I withhold information or provide false information, Dr. Donnelly and his staff are not held liable. I understand that the above information will be held in the strictest confidence and only be used to improve communication between Dr. Donnelly, his staff, and myself. I also give permission for Dr. Donnelly or his staff to use any photos he may take to be used for lecturing or education purposes. I consent to the diagnostic procedures and treatment by Dr. Donnelly necessary for proper dental care.

Patient or Responsible Party Signature: ____________________ **Date**____________

Patient or Responsible Party Printed Name: ____________________

INSURANCE INFORMATION

If you are covered by an active dental insurance policy, please fill out the following information:

Primary Insurance

Subscriber Name: _________________________ Relationship to Patient ___________________________

Subscriber D.O.B ___/___/_____ Subscriber Social Security Number: _________________

Subscriber Employer: ______________________

Secondary Insurance

Subscriber Name: _________________________ Relationship to Patient ___________________________

Subscriber D.O.B ___/___/_____ Subscriber Social Security Number: _________________

Subscriber Employer: ______________________

RESPONSIBLE PARTY INFORMATION

Name of Responsible Party : _______________________________ Relationship to patient: _____________

Address: __________________________ City_______________ State ___________ Zip __________

Cell Phone: (___) ___________ Work Phone: (____) _____________ Home Phone: (____) _________

Social Security Number: _____________________ D.O.B ___/___/_____ Martial Status ______________

Financial arrangements must be made prior to treatment. We have several options available and will be happy to discuss them with you. If you have dental insurance you will be billed directly for the services provided and you will be personally responsible for the payment of all dental services at the time of treatment regardless of insurance benefits. Our office will assist you in filing all necessary insurance forms and help you maximize your benefits for your treatment.

Please note that we are an out-of-network provider. We make every effort to accurately estimate your benefits prior to your appointment, however, most insurance companies do not give accurate estimates until the actual claim is received and processed. **The benefits we are given by the insurance company are an ESTIMATE only and not a guarantee of payment.**

Patient or Responsible Party Signature: ____ **Date________________**

Patient or Responsible Party Printed Name: ______________________________________

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of Dr. Donnelly's Notice of Privacy Practices, which has an effective date of 08/01/2016, and which describes how my health information may be used and disclosed. I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

Patient or Responsible Party Signature: ____ **Date________________**

Patient or Responsible Party Printed Name: ______________________________________