

## **Welcome To Our Practice**

## Barksdale and Hastings DDS 2606A Bens Branch Drive Kingwood, TX 77339 281-358-3843

## PATIENT INFORMATION

First Name:	M.ILast Name									
Preferred Name:										
Birth Date:	Social Security Number: Sex: $\square$ M or $\square$ F									
Address:		_								
City	StateZip									
Home Phone:	Cell Phone:Work Phone:									
Email address:										
Marital Status: □ Minor □ Single □ Married □ Divorced □ Widowed										
Person Financially Responsible fo	this account: (If different than patient):									
Phone:	_Address:									
Date of last Dental check-up	Referred by:									
		_								
DENTAL NSURANCE INFORMAT	ON									
	Relationship to patient:									
	mployer name: Group #									
	Insurance company phone number:									
	City:State:Zip									
Claim maining address.										

Continue on back of this page  $\rightarrow$ 

## PATIENT MEDICAL HISTORY

Dat	e of last e	xan	1							Yes	No		
1.	L. Are you currently under the care of a physician or been hospitalized in the last 5 years?												
	Expl	ain:				F - 17 - 12 - 17 ,							
										_			
2.~	Have you	ı ev	er had prolonged bleeding	g from	an	injury of tooth extraction?				🗆	С		
3.	Are you	Are you taking any drugs, medications or vitamins at this time?											
	Plea	ا مء	ist holow or provide a list	or lot		opy your current medication list							
	rica	3C 1	ist below of provide a list	oi iet	us c	opy your current medication list							
										-			
4.	Are you	allei	rgic to any drugs, medicat	ions l	ates	or metals? (List)				П			
•	, u.e. you	uc.	Sie to diff diago, medicat	10113, 1	u (C)	(c) metals: (clst)							
	-									_			
5.	Have you	ı təl	ven or are you currently to	king (	-oca	max, Boniva, Actonel or other bio	nhacnh	ato	-2	_			
J.	riave you	Lai	ken of are you currently to	ikiiig i	036	max, bolliva, Actoriel of other bio	priospi	iate	) !	0			
	Whe	en:_				For how long:	1		. N - 17 - 12 R 1	_			
6.	Women	only	<i>r</i> •			Yes No							
0.			, . r Pregnant/Possibly Pregn	ant?									
			Nursing?										
7.	Do you h	ave	any of the following cond	litions	?								
	Yes			Yes			Yes	No					
			Heart Disease/Trouble			Kidney Disease			Stomach Trouble/Ulce	ers			
			Artificial Heart Valve			Tuberculosis			TMJ Disorder				
			Cardiac Pacemaker			Herpes			Thyroid Problem				
			Rheumatic Fever			AIDS or HIV Infection			Radiation Therapy				
			High Blood Pressure			Joint Replacement or Implant			Sinus Problems				
			Stroke			Asthma/Emphysema			<b>Respiratory Problems</b>				
			Diabetes			Glaucoma			Arthritis				
8.	Do you h	ave	any Disease, Condition of	Prob	lem	not listed above?			***	7 114	_		
						D	ate						