



2110 East Rusk Street  
 Jacksonville, TX 75766  
 Phone 903.586.0741  
 Fax 903.586.0649

[www.allsmilesjacksonville.com](http://www.allsmilesjacksonville.com)

**DENTAL HISTORY**

Patient name \_\_\_\_\_ Referred by \_\_\_\_\_  
 Previous dentist \_\_\_\_\_ For how long? \_\_\_\_\_  
 Most recent dental exam \_\_\_\_\_ Most recent dental x-ray \_\_\_\_\_  
 Most recent dental treatment \_\_\_\_\_  
 How often do you have your teeth cleaned?    3 months    4 months    6 months    1 year or longer

**YOUR IMMEDIATE DENTAL CONCERN(S)?**

**PLEASE ANSWER YES OR NO TO THE FOLLOWING:**

Unhappy with the appearance of your teeth?.....	YES	NO	Unpleasant taste or odor in your mouth? .....	YES	NO
Unfavorable dental experiences?.....	YES	NO	Dry mouth, throat, and or eyes?.....	YES	NO
Dental fears? .....	YES	NO	Jaw problems (temporomandibular joint)? .....	YES	NO
Problems with effectiveness or bad reactions to dental anesthetic? .....	YES	NO	Difficulty opening your mouth widely? .....	YES	NO
Orthodontic treatment (braces)?.....	YES	NO	Stiff neck muscles?.....	YES	NO
Periodontal (gum) treatment?.....	YES	NO	Awaken with an awareness of your teeth or jaws?.....	YES	NO
Bleeding gums?.....	YES	NO	Tension headaches?.....	YES	NO
Avoid brushing any part of your mouth?.....	YES	NO	Clench or grind your teeth? .....	YES	NO
Part of your mouth sensitive to temperature?.....	YES	NO	Jaw clicking or popping? .....	YES	NO
Sore teeth? .....	YES	NO	Lost any teeth? .....	YES	NO
Burning sensation in your mouth?.....	YES	NO	Sweat or tremble alot during examination? .....	YES	NO
Difficulty swallowing?.....	YES	NO	Strange people or places make you afraid?.....	YES	NO

**SUPPLEMENTAL DENTURE HISTORY:**

**If you are wearing a partial or complete artificial denture, please complete the following:**

Has your present denture been relined? ..... YES NO  
 If yes, when (month/year)  
 Is your present denture a problem?..... YES NO  
 If yes, describe  
 Satisfied with the appearance? ..... YES NO  
 Satisfied with the comfort? ..... YES NO  
 Satisfied with the chewing ability?..... YES NO  
 When did you receive your first partial or complete denture?  
 How long have you worn your present denture?

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**NOTE: If remitting electronically via email or fax, patient will sign and date at first office visit.**



**MEDICAL HISTORY**

Patient Name \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_

Name of medical physician \_\_\_\_\_

Most recent physical examination \_\_\_\_\_ Purpose \_\_\_\_\_

What is your estimate of your general health? Poor Fair Good

**HAVE YOU EVER HAD THE FOLLOWING?**

Hospitalization for illness or injury .....	YES	NO	Diabetes .....	YES	NO
Allergic reaction to			Stomach or duodenal ulcer.....	YES	NO
Aspirin, ibuprofen, acetaminophen			Digestive disorders.....	YES	NO
Penicillin			Arthritis .....	YES	NO
Erythromycin			Glaucoma .....	YES	NO
Tetracycline			Contact lenses.....	YES	NO
Codeine			Head or neck injuries.....	YES	NO
Local anesthetic			Epilepsy or convulsions (seizures) .....	YES	NO
Fluoride			Viral infections and cold sores.....	YES	NO
Metals (gold, stainless steel)			Any lumps or swelling in the mouth.....	YES	NO
Latex			Hives, skin rash, hay fever .....	YES	NO
Any other medications			Venereal disease.....	YES	NO
Heart problems .....	YES	NO	Hepatitis - Type A B C D E.....	YES	NO
Heart murmur .....	YES	NO	HIV / AIDS .....	YES	NO
Rheumatic fever .....	YES	NO	Tumor, abnormal growth.....	YES	NO
Scarlet fever .....	YES	NO	Radiation therapy .....	YES	NO
High blood pressure .....	YES	NO	Chemotherapy.....	YES	NO
Low blood pressure .....	YES	NO	Emotional problems.....	YES	NO
A stroke.....	YES	NO	Psychiatric treatment.....	YES	NO
Artificial prosthesis (i.e., heart valve or joints) .....	YES	NO	Antidepressant medication .....	YES	NO
Anemia or other blood disorder .....	YES	NO	<b>ARE YOU:</b>		
Prolonged bleeding due to a slight cut .....	YES	NO	Presently being treated for any illness.....	YES	NO
Emphysema.....	YES	NO	Aware of a change in your general health.....	YES	NO
Tuberculosis .....	YES	NO	Often exhausted or fatigued .....	YES	NO
Asthma .....	YES	NO	Subject to frequent headaches.....	YES	NO
Sinus problems.....	YES	NO	A heavy smoker (one pack or more per day).....	YES	NO
Kidney disease .....	YES	NO	Considered a touchy person.....	YES	NO
Liver disease .....	YES	NO	Often unhappy or depressed.....	YES	NO
Jaundice .....	YES	NO	Easily upset or irritated .....	YES	NO
Thyroid or parathyroid disease.....	YES	NO	Female - taking birth control pills.....	YES	NO
Hormone deficiency.....	YES	NO	Female - pregnant.....	YES	NO
High cholesterol.....	YES	NO	Male - prostate disorders.....	YES	NO

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

List any medications, herbal supplements and/or vitamins taken within the last two years:

**PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.**

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

DOCTOR'S REMARKS \_\_\_\_\_

DOCTOR'S SIGNATURE \_\_\_\_\_

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**CONFIDENTIAL QUESTIONNAIRE**

PATIENT'S NAME: LAST FIRST MIDDLE

DATE OF BIRTH GENDER: M F SOCIAL SECURITY #

PATIENT'S ADDRESS: STREET APT# CITY STATE ZIP

EMAIL HOME PHONE CELL PHONE

MARITAL STATUS: MARRIED SINGLE UNDER AGE 18

PATIENT'S/GUARDIAN'S EMPLOYER OCCUPATION

WORK ADDRESS: STREET CITY STATE ZIP

WORK PHONE OK TO CALL WORK? YES NO

SPOUSE'S NAME: LAST FIRST MIDDLE

SPOUSE'S EMPLOYER OCCUPATION WORK PHONE OK TO CALL WORK? YES NO

WORK ADDRESS: STREET CITY STATE ZIP

PERSON WE CAN CONTACT IN CASE OF EMERGENCY (OTHER THAN YOUR FAMILY HOME)

NAME RELATIONSHIP

HOME # WORK # CELL #

OTHER FAMILY MEMBERS WHO ARE PATIENTS HERE

WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?

**INSURANCE AND FINANCIAL INFORMATION**

INSURANCE? YES NO INSURANCE COMPANY NAME

ADDRESS CITY STATE ZIP PHONE

SUBSCRIBER'S NAME PATIENT'S RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE DEPENDENT

SUBSCRIBER'S DATE OF BIRTH: SUBSCRIBER'S SSN: GROUP/PROGRAM NUMBER

EMPLOYER (IF DIFFERENT FROM ABOVE) EMPLOYER ADDRESS

SECONDARY INSURANCE? YES NO INSURANCE COMPANY NAME

ADDRESS CITY STATE ZIP PHONE

SUBSCRIBER'S NAME PATIENT'S RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE DEPENDENT

SUBSCRIBER'S DATE OF BIRTH: SUBSCRIBER'S SSN: GROUP/PROGRAM NUMBER

EMPLOYER (IF DIFFERENT FROM ABOVE) EMPLOYER ADDRESS

**ASSIGNMENT & RELEASE:**

I hereby authorize my insurance benefits to be paid directly to All Smiles. I am financially responsible for any balances due and authorize All Smiles to release any information for this claim. I authorize that my records can be used by All Smiles if it so determines.

In consideration of the services rendered to me by All Smiles, I am obligated to pay said office in accordance with its credit terms and policy. I consent to the making of videotapes, photographs, and x-rays before, during, and after treatment, and to the use of same by All Smiles in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

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# HIPAA CONSENT FORM

Charlie Stocks, D.D.S.    Bradley K. Westbrook, D.D.S.

My signature confirms that I have been informed and understand my rights to privacy regarding protected information, under the **Health Insurance Portability & Accountability Act of 1996 (HIPAA)**. I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to provide, conduct and direct my treatment among the appropriate health care providers who may be involved in that treatment directly and indirectly as well as obtain payment from third party payers.

I have read and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I also understand that I may request in writing that you restrict how my private information is used or disclosed to carry out my treatment, payment or other health care operations. I understand that All Smiles has the right to change the Notice of Privacy Practices and I have the right to contact this office to obtain a copy.

I have read and understand that in signing this HIPAA form, I acknowledge and authorize, that All Smiles provided this HIPAA Notice of Privacy Practices for my knowledge and my consent.

Patient's name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to patient (if parent or guardian): \_\_\_\_\_

Patient or Guardian's signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **Authorization for Release of Information to Family Members**

I authorize All Smiles Jacksonville to release my medical and/or billing information to the following individual(s):

1. \_\_\_\_\_ Relation to Patient: \_\_\_\_\_
2. \_\_\_\_\_ Relation to Patient: \_\_\_\_\_
3. \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

**You have the right to revoke this consent in writing.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_