

4305 Garfield #225 Midland, TX 79705

432-685-7011 www.Boylesgeneraldentistrymtx.com

Welcome to our office!

We sincerely appreciate you choosing us as your dental office and look forward to serving your dental needs!

Patient's Name:								
Patient's Date of Birth:	(First) Sex: (M)	(F)	Ht: _	(Middle) ' _ Wt.: _	lbs		
Parent or Responsible person's name								
Address (of responsible person): _								
City, State, Zip Code:								
•								
Telephone Numbers:(Home)	phone # preferred f	Business) or confirming	appo	ointme	(Cell)			
Email address (also used for confirm								
Occupation:	Employer:							
Marital Status:(Single) (Married) (D	ivorced) (Widowed)S	pouse's Name	e:					
Spouse's Employer:	Bus. ph	none			_ Cell			
Dental Insurance Co:		ss#	:			x		
(SS# required for filing insurance)	S	pouses SS#:						
Emergency contact person:	erson:Phone:							
What is the reason for today's vis	it?							
Who can we thank for REFERRIN	G YOU?							
I agree to assume full financial respons anesthetics that are considered necessions.	ary for the proposed tre	atment that will	be ful	ly discu	ussed and understo	ood prior to		
proceeding. I also permit the release of following health history is accurate and	any information to or from	om my physicia	an as r	nay be	required and attes	t that the		
Signature of Patient, Parent of	or Guardian	Signat	ture of [Dentist/V	Vitness			
Are you having any discomfort at this tin	ne? How long	since you have	seen a	dentis	t?			
How long since cleaning?	_ Have you ever had gu	m treatments?_		V	Vhen?			
Are your teeth sensitive to: Heat?	old? Sweets?	Pressure?	Whe	ere?				
3								
	(See back	for more)						

Name		BP:	/	P	Date
(Above for office use only)				****************	
Have you had your teeth straight	ened? When?D	o currentiv i	nave l	bleedina aums?	
Do you have any fear of dental tro	eatment? None Mild	Modera	ite	Severe	
	al treatment with only local anesthe	tic?	Ha	ve you had wisdo	m teeth extracted? _
<u>Medical History:</u>					
Physician's Name:	Phone#_			Date Last Phy	ysical Exam
Are You Taking Any Medica	tions Prescribed by a Physic	ian?(Y) (N	l) Lis	st medications	and dosage belo
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Are you allergic to any me	dications or substances? (Y)(N)List	plea	ase	
				· · · · · · · · · · · · · · · · · · ·	
De veu beve env ef the fe	Mousing. (Diames indiants VES	Y sociela m. n.l.			
Any Heart Disease	ollowing: (Please indicate <u>YES</u> Do you SMOKE or dip snuff?				
Heart Murmur				-	se
Mitral Valve Prolapse	How much?				
High Blood Pressure	Venereal Disease				
Low Blood Pressure	HPV				
Circulatory Problems	Aphthous canker sores				
Artificial Heart Valve-	Herpes/Fever Blisters/cold sore				·
Hemophilia	AIDS or HIV pos				
Excessive Bleeding	Malignancies (Cancer)				
Blood Transfusions	What kind?				
Anemia	Radiation Treatments			• •	tis 🗆
Stroke	Where radiated?		_	-	s
Heart Pacemaker	Chemotherapy				e
Artificial Joint	Osteoporosis	*****			
Fainting/Dizzy Spells	Surgery requiring general anest				lication
Autoimmune disease	Diabetes and Type	*****		When?	
Epilepsy	Liver Disease/Hepatitis			Are You Pregi	nant?
Medical updates:					
DateChanges?_					
Date Changes? _					
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