Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any question or need assistance, please ask us – we will be happy to help.

Vickers Family Dental

Stephen L. Vickers, DDS
13810 Champion Forest Drive, Suite 204
Houston, Texas 77069
Phone: 281-440-1200 Call or Text
Fax: 281-440-3578
Email: vickersdental@aol.com
Website: www.vickersdental.com

Patient Information (Confidential)

Today's Date:_____

Full Name_____Date of Birth_____Social Security #_____
(Required to check eligibility on most insurance)

Daytime Phone_____Email Address_____

Address_____City_____State_____Zip _____

Check : Minor____ Single____ Married____ Divorced____ Widowed____ Other:_____

Employer_____Work Phone_____

Spouse or Guardian's Name_____Work Phone_____

Whom may we thank for referring you?_____

Person to contact in case of emergency_____Phone_____

Please Provide Pharmacy_____Address or Intersection_____Phone_____

Responsible Party

Name of person responsible for this account_____Relationship to Patient_____

Social Security #_____Date of Birth_____

Daytime Phone_____Email Address_____

Address_____City_____State_____Zip _____

Is this person currently a patient at our office?_____

Insurance Information

Name of Insured_____

Relationship To Patient_____Date of Birth_____Social Security #_____

Name of Employer_____Parent Company_____

Dental Insurance Company_____Group #_____

Dental Insurance Address:_____City_____State_____Zip_____

ID#_____Provider Phone Number_____

Do you have a secondary insurance?_____ If yes, complete the following:

Dental Insurance Company_____Group #_____

Dental Insurance Address:_____City_____State_____Zip_____

ID#_____Provider Phone Number_____

Patient Medical History

Physician_____ Office Phone_____ Date of Last Exam_____

	Yes	No
1. Are you under medical treatment now?		
2. Have you been hospitalized for any surgical procedures or serious illness in the past five years? If yes, please explain:_____		
3. Are you taking any medications, including non-prescription? If yes, please list medications:_____		
4. Have you ever taken Phen-Fen/Redux?		
5. Do you use tobacco?		
6. Do you use controlled substances?		
7. Are you wearing contact lenses?		

8. Are you allergic to or have you had any reactions to the following:

	Yes	No
Local Anesthetics (ex. Novocaine)		
Penicillin or other antibiotics		
Sulfa Drugs		
Sedatives		
Iodine		
Aspirin		
Any Metals (ex. Nickel, mercury, etc.		
Latex Rubber		
Others:_____		

9. Women Only:

Are you pregnant or think you may be pregnant?		
Are you nursing?		
Are you taking oral contraceptives?		

10. Do you have or have you had any of the following?

	Yes	No
High Blood Pressure		
Low Blood Pressue		
Heart Attack		
Rheumatic Fever		
Swollen Ankles		
Fainting/Seizures		
Epilepsy/Convulsions		
Asthma		
Leukemia		
Diabetes		
Kidney Disease		
AIDS or HIV Infection		
Thyroid Problem		

	Yes	No
Heart Disease		
Cardiac Pacemaker		
Heart Murmur		
Angina		
Frequently Tired		
Anemia		
Emphysema		
Cancer		
Arthritis		
Joint Replacement/Implant		
Hepatitis/Jaundice		
Sexally Transmitted Disease		
Stomach Trouble/Ulcers		

	Yes	No
Chest Pains		
Easily Winded		
Stroke		
Hay Fever/Allergies		
Tuberculosis		
Radiation Therapy		
Glaucoma		
Recent Weight Loss		
Liver Disease		
Heart Trouble		
Respiratory Problems		
Mitral Valve Prolapse		
Other:_____		

Patient Dental History

Name of previous dentist and location_____ Date of last exam_____

	Yes	No
1. Do your gums bleed while brushing or flossing?		
2. Are your teeth sensitive to hot or cold liquids/foods?		
3. Are your teeth sensitive to sweet or sour liquids/foods?		
4. Do you feel pain in any of your teeth?		
5. Do you have any sores or lumps in or near your mouth?		
6. Have you had any head, neck or jaw injuries?		
7. Have you ever experienced any of the following with your jaw?		
Clicking		
Pain (joint,ear, side of face)		
Difficulty opening or closing		
Difficulty chewing		

	Yes	No
8. Do you have frequent headaches?		
9. Do you clench or grind your teeth?		
10. Do you bite your lips or cheeks frequently?		
11. Have you ever had any difficult extractions in the past?		
12. Have you ever had prolonged bleeding following extractions?		
13. Have you had any orthodontic treatment?		
14. Do you wear dentures or partials? If yes, date of placement_____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?		
16. Do you like your smile?		

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Stephen L. Vickers and associated staff to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist, Stephen L. Vickers dba Vickers Family Dental; I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of Patient or Patient's Guardian Date

Doctor's comments:_____

_____

_____ Signature_____ Date_____