Perez Family Dental
Azzah Mary Perez, D.D.S.
2715 W. Berry St. ❍ Fort Worth, Texas 76109
Ph: 817-922-8552 ❍ Fax: 817-922-9286

WE ARE PLEASED TO WELCOME YOU TO OUR PRACTICE, PLEASE TAKE A FEW MINUTES TO FILL OUT THIS FORM AS COMPLETELY AS YOU CAN.

Patient Information

Date_____

Name_____ Phone( )_____
First Last

Sex M____ F____ Birthdate_____

Soc. Sec. #_____ Driver License#_____

Child___ Single___ Married___ Widowed___ Seperated___ Divorced___

Address_____ City_____ State____ Zip_____

Employed by_____ Occupation_____

Has any other family member been here before?____ Name_____ Relationship_____

If student, School name_____

Address_____ City_____ State____ Zip_____

Insurance Name_____ Telephone #_____

Whom may we thank for referring you?_____

In case of emergency who should be notified?_____

Phone# ( )_____ Relationship_____

If patient is a child fill out next part

Responsible person_____ Relationship to Patient_____

Birthdate_____ Soc.Sec.#_____

Sex M___ F___ Single____ Married____ Widowed___ Separated___ Divored__

Driver License#_____ Phone #_____

Address_____ City_____ State_____ Zip_____

Employed by_____ Occupation_____

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Dental History

Reason for Today's Visit_____

Date of last dental visit_____ Dentist Name:_____

Check if you have had problems with any of the following:

____Bad Breath	____Grinding teeth	____Sensitivity to hot
____Bleeding gums	____Loose teeth	____Sensitivity to sweets
____Clicking or popping jaw	____Broken fillings	____Sensitivity when biting
____Food collection between teeth	____Sensitivity to cold	____Sores or growths in your mouth

How often do you floss?_____ How often do you brush?_____

Medical History

Physician's Name_____ Date of Last Visit_____

Have you had any serious illnesses or operations? If yes, describe_____

Have you ever had a blood transfusion? ___Yes ___No If yes, give approximate date_____

List medications you are currently taking_____

Are you allergic to any medication?_____

(Women) Are you pregnant? __Yes __No Nursing?__Yes __No Taking birth control pills? __Yes __No

Check if you have or have had any of the following:

___Anemia	___Cortisone Treatments	___Hepatitis	___Shortness of breath
___Arthritis, Rheumatism	___Cough, Persistent	___High Blood Pressure	___Skin Rash
___Artificial Heart Valves	___Diabetes	___HIV/AIDS	___Stroke
___Artificial Joints	___Epilepsy	___Jaw Pain	___Swelling
___Asthma	___Fainting	___Liver Disease	___Thyroid Problems
___Back Problems	___Glaucoma	___Kidney Disease	___Tobacco Habit
___Blood Disease	___Headaches	___Pacemaker	___Tonsillitis
___Cancer	___Heart Murmur	___Radiation Treatment	___Tuberculosis
___Chemotherapy	___Heart Problems	___Respiratory Disease	___Ulcer
___Circulatory Problems	___Hemophilia	___Rheumatic Fever	___Venereal Disease

I understand that payment is due in full at time of treatment unless prior arrangements have been approved.

Signature_____ Date_____
(If patient is a child, parent signature is needed)