NEW PATIENT REGISTRATION

CANYON GOLF FAMILY DENTISTRY

Bryan E. Soto, DDS

20210 Stone Oak Pkwy Ste. 209 • San Antonio, Texas 78258
P: 210-787-2062 • F: 210-341-3259
www.canyongolfdentistry.com

Patient's Name:_____ Preferred Name:_____

SSN:_____ Date of Birth:_____ Gender: ◯Male ◯Female

Address:_____ Driver's License#:_____

City:_____ State:_____ Zip:_____ Home Phone:_____

Email:_____ Mobile Phone:_____

Marital Status: ◯Single ◯Married ◯Divorced/Separated ◯Widowed ◯Domestic Partner Work Phone:_____

Employment: ◯Full-time ◯Part-Time ◯Retired Occupation:_____ Employer:_____

Student Status: ◯Full-time ◯Part-Time School/College:_____ Emergency Contact:_____

How were you referred to our office? ◯Insurance ◯Current Patient ◯Mail/Brochure ◯Other Contact Phone:_____

Please indicate your preferred method of contact for appointment confirmation: ◯Email ◯Text ◯Home Phone ◯Mobile Phone ◯Work Phone

Name of Previous DDS:_____ Previous DDS Phone:_____

Preferred Pharmacy:_____ Pharmacy Phone:_____

Do you require a Pre-Medication for dental appointments? ◯Yes ◯No

RESPONSIBLE PARTY

Name of Person Responsible for this Account:_____ Relationship to Patient:_____

SSN:_____ Date of Birth:_____ Gender: ◯Male ◯Female

Address:_____ Driver's License#:_____

City:_____ State:_____ Zip:_____ Home Phone:_____

Email:_____ Mobile Phone:_____

Is the Responsible Party a Current Patient in Our Office? ◯Yes ◯No Employer:_____

PRIMARY INSURANCE

Name of Policy Holder:_____ Relationship to Patient:_____

SSN:_____ Date of Birth:_____ Gender: ◯Male ◯Female

Name of Policy Holder's Employer:_____ Employer Phone:_____

Insurance Company:_____ Insurance Phone:_____

Policy Holder Member ID#:_____ Group#:_____

SECONDARY INSURANCE

Name of Policy Holder:_____ Relationship to Patient:_____

SSN:_____ Date of Birth:_____ Gender: ◯Male ◯Female

Name of Policy Holder's Employer:_____ Employer Phone:_____

Insurance Company:_____ Insurance Phone:_____

Policy Holder Member ID#:_____ Group#:_____

■ PLEASE COMPLETE MEDICAL/DENTAL HISTORY ON BACK. ■

PATIENT MEDICAL HISTORY

Although dental personnel primarily treat the area around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following:

Are you currently under a physician's care? ◯Yes ◯No If yes, explain:_____
Have you ever been hospitalized or had a major operation? ◯Yes ◯No If yes, explain:_____
Have you ever had a head, neck, or jaw injury? ◯Yes ◯No If yes, explain:_____
Do you take, or have you taken Phen-Fen or Redux? ◯Yes ◯No If yes, explain:_____
Are you currently on a special diet? ◯Yes ◯No If yes, explain:_____
Do you use tobacco (in any form)? ◯Yes ◯No If yes, explain:_____
Do you use controlled substances? ◯Yes ◯No If yes, explain:_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯Yes ◯No If yes, please indicate:_____
Are you taking any medications, pills, herbal remedies, or drugs (including non-prescription)? ◯Yes ◯No If yes, please list:_____

_____

Are you allergic to any of the following? ◯Aspirin ◯Penicillin ◯Codeine ◯Local Anesthetics ◯Acrylic ◯Metal ◯Latex Rubber ◯Sulfa Drugs ◯Other If yes, please explain:_____

Women ONLY: Are you? ◯Pregnant/Trying To Get Pregnant ◯Nursing ◯Taking Oral Contraceptives If pregnant, how many weeks?_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯Yes ◯No	Diabetes ◯Yes ◯No	Hepatitis A ◯Yes ◯No	Recent Weight Loss ◯Yes ◯No
Alzheimer's Disease ◯Yes ◯No	Drug/Alcohol Addiction ◯Yes ◯No	Hepatitis B or C ◯Yes ◯No	Renal Dialysis ◯Yes ◯No
Anaphylaxis ◯Yes ◯No	Easily Winded ◯Yes ◯No	Herpes ◯Yes ◯No	Rheumatic Fever ◯Yes ◯No
Anemia ◯Yes ◯No	Emphysema ◯Yes ◯No	High Blood Pressure ◯Yes ◯No	Rheumatism ◯Yes ◯No
Angina ◯Yes ◯No	Epilepsy or Seizures ◯Yes ◯No	High Cholesterol ◯Yes ◯No	Scarlet Fever ◯Yes ◯No
Arthritis/Gout ◯Yes ◯No	Excessive Bleeding ◯Yes ◯No	Hives or Rash ◯Yes ◯No	Shingles ◯Yes ◯No
Artificial Heart Valve ◯Yes ◯No	Excessive Thirst ◯Yes ◯No	Hypoglycemia ◯Yes ◯No	Sickle Cell Disease ◯Yes ◯No
Artificial Joint ◯Yes ◯No	Fainting Spells/Dizziness ◯Yes ◯No	Irregular Heartbeat ◯Yes ◯No	Sinus Trouble ◯Yes ◯No
Asthma ◯Yes ◯No	Frequent Cough ◯Yes ◯No	Joint Replacement or Implant ◯Yes ◯No	Spina Bifida ◯Yes ◯No
Blood Disease ◯Yes ◯No	Frequent Diarrhea ◯Yes ◯No	Kidney Problems/Disease ◯Yes ◯No	Stomach/Intestinal Disease ◯Yes ◯No
Blood Transfusion ◯Yes ◯No	Frequent Headaches ◯Yes ◯No	Leukemia ◯Yes ◯No	Stroke ◯Yes ◯No
Breathing/Respiratory Problem ◯Yes ◯No	Frequently Tired ◯Yes ◯No	Liver Disease ◯Yes ◯No	Swelling of Limbs ◯Yes ◯No
Bruise Easily ◯Yes ◯No	Genital Herpes ◯Yes ◯No	Low Blood Pressure ◯Yes ◯No	Thyroid Problems/Disease ◯Yes ◯No
Cancer ◯Yes ◯No	Glaucoma ◯Yes ◯No	Lung Disease ◯Yes ◯No	Tonsillitis ◯Yes ◯No
Chemotherapy ◯Yes ◯No	Hay Fever/Allergies ◯Yes ◯No	Mitral Valve Prolapse ◯Yes ◯No	Tuberculosis ◯Yes ◯No
Chest Pains ◯Yes ◯No	Heart Attack/Failure ◯Yes ◯No	Osteoporosis ◯Yes ◯No	Tumors or Growths ◯Yes ◯No
Cold Sores/Fever Blisters ◯Yes ◯No	Heart Murmur ◯Yes ◯No	Pain in Jaw Joints ◯Yes ◯No	Ulcers ◯Yes ◯No
Congenital Heart Disorder ◯Yes ◯No	Heart Pacemaker ◯Yes ◯No	Parathyroid Disease ◯Yes ◯No	Venereal Disease ◯Yes ◯No
Convulsions ◯Yes ◯No	Heart Trouble/Disease ◯Yes ◯No	Psychiatric Care ◯Yes ◯No	Yellow Jaundice ◯Yes ◯No
Cortisone Medicine ◯Yes ◯No	Hemophilia ◯Yes ◯No	Radiation Treatments ◯Yes ◯No	Wear Contact Lenses/Lasik ◯Yes ◯No

Do you have any disease, condition or problem that we should know about? ◯Yes ◯No If yes, please list:_____

_____

PATIENT DENTAL HISTORY

Do your gums bleed while brushing or flossing? ◯Yes ◯No
Are your teeth sensitive to hot or cold liquids/foods? ◯Yes ◯No
Are your teeth sensitive to sweet or sour liquids/foods? ◯Yes ◯No
Do you feel pain to any of your teeth? ◯Yes ◯No
Do you have any sores or lumps in or near your mouth? ◯Yes ◯No
Do you bite your lips or cheeks frequently? ◯Yes ◯No
Have you ever had a difficult tooth extraction in the past? ◯Yes ◯No
Have you ever had any prolonged bleeding following a tooth extraction? ◯Yes ◯No
Have you ever had gum disease, a deep cleaning, or scaling and root planing? ◯Yes ◯No
Have you ever received oral hygiene instructions for your teeth and gums? ◯Yes ◯No
Do you gag easily? ◯Yes ◯No
Are you apprehensive about dental treatment? ◯Yes ◯No
Do you like your smile? ◯Yes ◯No

Have you had any orthodontic treatment? ◯Yes ◯No
Are you interested in whitening your teeth? ◯Yes ◯No
Have you ever experienced clicking in your jaw? ◯Yes ◯No
Are you aware of clenching or grinding your teeth? ◯Yes ◯No
Do you have pain in the face, cheeks, jaw, joints, throat or temples? ◯Yes ◯No
Does it hurt when you chew or open wide to take a bite? ◯Yes ◯No
Do you wear dentures or partials? ◯Yes ◯No
If you wear dentures or partials, what was the estimated date of placement? _____
When was your last dental cleaning/visit? _____
How many times per week do you floss your teeth? _____
How many times per day do you brush your teeth? _____
Is there a specific service and/or concern you would like to inquire about? ◯Yes ◯No
If yes, please indicate: _____

AUTHORIZATION AND RELEASE

By submitting this information to Canyon Golf Family Dentistry, 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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I authorize the dentist 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 the request my insurance company (if applicable) to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____
Signature of Patient (or Parent/Guardian, if Minor)