Flores
DENTAL CARE

CONFIDENTIAL INFORMATION QUESTIONNAIRE:

PATIENT'S NAME LAST	FIRST	MIDDLE	DATE OF BIRTH	SEX	SOCIAL SECURITY #

PATIENT'S MAILING ADDRESS STREET	APT #	CITY	STATE	ZIP

PHONE #	ALTERNATE#	EMAIL ADDRESS
( ) -	( ) -	

MARITAL STATUS ☐M ☐S ☐D ☐W ☐UNDER AGE 18	GUARDIAN'S NAME (IF MINOR)	PATIENT'S/GUARDIAN'S EMPLOYER	OCCUPATION

WORK ADDRESS STREET	CITY	STATE	ZIP	WORK PHONE	OK TO CALL? ☐YES ☐NO

SPOUSE'S NAME LAST	FIRST	MIDDLE	SPOUSE'S EMPLOYER	OCCUPATION

WORK ADDRESS STREET	CITY	STATE	ZIP	WORK PHONE	OK TO CALL? ☐YES ☐NO

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

NAME	RELATIONSHIP	WORK #	HOME #

OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE	WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?

[redacted]

In order to protect your personal information, we will NOT give information about your appointments or treatment to non-medical personnel without your permission. We will therefore be asking each patient or guardian to appoint people who may be an exception for us to share information with. This exception may include spouses or other family members or relations. If you agree that your spouse or family members may access such information, please list them below

1._____ Relationship to patient _____

2._____ Relationship to patient _____

3. _____ Relationship to patient _____

CONSENT:

1. **The undersigned hereby authorizes doctor to take X-rays, study models, photographs, or other diagnostic aids deemed appropriate by doctor to make a through diagnosis of the patient's dental needs.**
2. **I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.**
3. **I understand that all responsibility for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that all +½% finance charge (18% APR) may be added to my account in addition to any collection charges.**
4. **I understand that, where appropriate, credit bureau reports may be obtained.**
5. **I understand that it is my responsibility to advise your office of any changes in the information contained on this form.**

Patient/Parent Signature _____Date_____

FOR OFFICE USE: _____DATE_____

MEDICAL HISTORY

Patient Name_____Nickname_____Age_____
Name of Physician_____
Most recent physical examination date_____Purpose_____
What is your estimate of your general health? Poor_____ Fair_____ Good_____

HAVE YOU EVER HAD THE FOLLOWING:	YES	NO
Hospitalization for illness or injury……..	☐	☐
Are you allergic to any of the following:		
☐ Aspirin		
☐ Penicillin		
☐ Erythromycin		
☐ Tetracycline		
☐ Codeine		
☐ Local Anesthetic		
☐ Flouride		
☐ Metals (gold, stainless steel)		
☐ Latex		
☐ Any other medication_____		
Heart problems……	☐	☐
Heart murmur……....	☐	☐
Rheumatic fever……	☐	☐
Scarlet fever……	☐	☐
High blood pressure……	☐	☐
Low blood pressure……	☐	☐
Stroke……	☐	☐
Artificial prosthesis (i.e. heart valve or joints)……	☐	☐
Anemia or other blood disorder……	☐	☐
Prolonged bleeding due to a slight cut……..……	☐	☐
Emphysema……	☐	☐
Tuberculosis……	☐	☐
Asthma……	☐	☐
Sinus Problems…….....	☐	☐
Kidney Problems…….. …	☐	☐
Liver Disease……	☐	☐
Jaundice……	☐	☐
Thyroid or Parathyroid disease……	☐	☐
Hormone Deficiency……	☐	☐
High Cholesterol……	☐	☐
Diabetes……	☐	☐

	YES	NO
Stomach or duodenal ulcers……..	☐	☐
Arthritis……	☐	☐
Osteoporosis……	☐	☐
Glaucoma……	☐	☐
Head or Neck Injuries…….....	☐	☐
Epilepsy, Convulsions (seizures)…….	☐	☐
Viral infections and cold sores……	☐	☐
Any lumps or swelling in the mouth……	☐	☐
Hives, skin rash, hay fever……	☐	☐
Venereal diseases……..	☐	☐
Hepatitis (type____)……	☐	☐
HIV / AIDS……..	☐	☐
Tumor, abnormal growth……	☐	☐
Cancer ……..……...	☐	☐
Chemotherapy / Radiation ……	☐	☐
Psychiatric treatment …. ……	☐	☐
Antidepressant medication ……	☐	☐
Alcohol / drug dependency ……	☐	☐
ARE YOU:		
Presently being treated for any illness…...	☐	☐
Aware of a change in your general health	☐	☐
A heavy smoker (1 pack or more a day)…	☐	☐
FEMALE – taking birth control pills……	☐	☐
FEMALE – pregnant……	☐	☐
MALE – prostate disorders……	☐	☐

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 past two years_____

_____

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

Patient/Parent Signature_____Date_____

Doctor's signature_____

DENTAL HISTORY

Referred by_____

Previous Dentist_____ How long_____

Most recent dental exam_____Most recent dental x-ray_____

Most recent dental treatment _____

How often do you have your teeth cleaned? 3mo._____ 4 mo._____ 6 mo._____ 1 year or longer_____

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	**YES**	**NO**
Unhappy with appearance of your teeth……	☐	☐
Unfavorable dental experiences……	☐	☐
Dental fears……	☐	☐
Problems with effectiveness or bad reactions to dental anesthetic……	☐	☐
Orthodontic treatment (braces) when……	☐	☐
Periodontal (gum) treatment when……	☐	☐
Bleeding gums……	☐	☐
Avoiding brushing any part of your mouth……	☐	☐
Part of your mouth is sensitive to temperature……	☐	☐
Sore teeth……	☐	☐
A burning sensation in your mouth……	☐	☐
Difficulty swallowing……	☐	☐
An unpleasant taste or odor in your mouth……	☐	☐
Dry mouth, throat, and/or eyes……	☐	☐
Jaw problems (temporomandibular joint)……	☐	☐
Difficulty opening your mouth widely……	☐	☐
Stiff neck muscles……	☐	☐
Awaken with an awareness of your teeth or jaws……	☐	☐
Tension headaches……	☐	☐
Clench or grind your teeth……	☐	☐
Jaw clicking or popping……	☐	☐
Lost any teeth……	☐	☐

SUPPLEMENTAL DENTURE HISTORY

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

YES	**NO**	(Please check Yes or No)
☐	☐	Has your present denture been relined? When_____
☐	☐	Is your present denture a problem? Describe_____
☐	☐	Satisfied with the appearance?_____
☐	☐	Satisfied with the comfort?_____
☐	☐	Satisfied with the chewing ability?_____
		When did you receive your first partial or complete denture?_____
		How long have you worn your present denture?_____

Patient/Parent Signature_____Date_____

Doctor's Signature_____

Flores
DENTAL CARE
Bringing a gentle touch to your smile

MISSED APPOINTMENT/LATE CANCEL POLICY

Thank you for choosing Flores Dental Care for your dental needs! We pride ourselves in our expert team and specialized care. We will tailor your treatment to your specific needs in each one-on-one appointment. Your appointment time is scheduled **exclusively** for you in an effort to best accommodate your schedule; we ask the same courtesy. Our staff will do our best to make sure that we run on time and make each appointment valuable to you and your needs. As a result of the time and energy placed into your treatment plan, we require a 24-hour cancelation notice. We understand that unforeseen circumstances occasionally occur and you may be unable to keep your scheduled appointment. Please see our missed/canceled appointment guidelines below.

If you are unable to keep your scheduled appointment, we require a minimum of 24-hour notice (1-full business day) so that we may accommodate the dental needs of another patient. This guideline applies to both visits with our hygienists and our doctor.

Doctor/Hygiene Visits: All patients will receive the opportunity to miss one scheduled appointment. Because we do not schedule several patients at the same time, all appointments are reserved exclusively for you. In the event of a late cancel/failed appointment, the patient will be charged a $30.00 fee. This fee must be paid before your next scheduled visit.

Thank you for choosing Flores Dental Care as you dental health provider.

Dr. Sylvia R. Flores

Patient/Parent Signature: _____ Date: _____

1506 E. Griffin Parkway, Suite D
Mission, TX 78572
Phone (956) 583-0055
Fax (956) 583-0090
www.FloresDentalCare.com