David K. Dennison, DDS, MS, PhD
Diplomate of the American Board of Periodontology
University Periodontal Associates, Inc 713▪523▪9040

Patient Information

Patient Name: _____Date: _____
Last, First MI (Preferred Name)
Circle one: Male Female Married Single Child Other: _____ Email: _____
Social Security #: _____ Birth Date: _____DL#: _____
Phone (Home): _____ (Work): _____Ext: _____ (Cell): _____
Address: _____
Street Apartment #
_____
City State Zip Code
Employer Name: _____

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐ Another patient, relative ☐Dental Office
☐ Internet/Google _____ ☐ H Texas Magazine ☐Yellow Pages ☐School ☐Work ☐Other _____
Name of person or office referring you to our practice: _____

Health History

Name of Physician: Phone: _____ Date last seen: _____
Are you now under the care of a physician: ☐Yes ☐No
Have you been admitted to a hospital or needed emergency care during the past two years? ☐Yes ☐No
Please list any medications you are currently taking: _____
Please list any medications you are allergic to: _____
Do you have or have you ever had any of the following conditions? (Please check those that apply)

☐AIDS/HIV	☐Dizziness	☐Hepatitis	☐Penicillin Allergy	☐Tuberculosis
☐Anemia	☐Epilepsy	☐High Blood Pressure	☐Pregnancy	☐Tumors
☐Arthritis	☐Excessive Bleeding	☐Jaundice	Due Date: _____	☐Ulcers
☐Artificial Joints	☐Fainting	☐Kidney Disease	☐Radiation Treatment	Other:
☐Asthma	☐Glaucoma	☐Liver Disease	☐Respiratory Problems	☐_____
☐Blood Disease	☐Hay Fever	☐Mental Disorders	☐Rheumatic Fever	☐_____
☐Cancer	☐Head injuries	☐Metal or Latex allergy	☐Sinus problems	
☐Codeine Allergy	☐Heart Disease	☐Other Allergies:	☐ Stomach problems	
☐Diabetes	☐Heart Murmur	_____	☐Stroke	

▪Do you smoke or chew tobacco? ☐Yes ☐No
▪Do you have any health problems that need further clarification? ☐Yes☐ No

Dental History

Date of Last Dental Visit: _____ Do you brush and floss on a daily basis? ☐Yes ☐No
▪Have you ever had any complications following dental treatment? ☐Yes ☐No
▪Are you having pain or discomfort at this time? ☐Yes ☐No
▪Are you nervous or apprehensive about your dental treatment? ☐Yes ☐No
▪Are you unhappy with the appearance of your teeth? ☐Yes ☐No
▪Have you ever had an unusual reaction to dental anesthetic? ☐Yes ☐No
▪Do you have or have you ever had any of the following? (Please check those that apply)

☐Bleeding or sore gums	☐Food trapped between teeth	☐Periodontal (gum) Treatment
☐Loose/shifting teeth	☐Complications from extractions	☐Clinching or grinding teeth
☐Sensitivity to hot/cold/sweets	☐Orthodontic treatment (braces)	☐Pain/clicking/popping of jaw

Health Questionnaire Acknowledgment

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

_____ Date: _____
Signature of patient, parent or guardian

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Responsible Party Information (if not you)

Name: _____ Relationship to patient: _____
☐Male ☐Female ☐Married ☐Single ☐Child ☐Other
Social Security #: _____ Birth Date: _____
Email: _____ DL#: _____
Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Address: _____
Street Apartment #
_____
City State Zip code

Dental Insurance Information

Name of Insured: _____ Is insured a patient? ☐Yes ☐No
Last First MI
Patient's relationship to insured: ☐Self ☐Spouse ☐Child ☐Other _____ Insured's SS#: _____
Insured's Employer Name: _____ Address: _____ Phone: _____
Insurance Plan Name: _____ Address: _____ Phone: _____
Insured's Birth Date: _____ID #: _____ Group #: _____
Insured's Address (if different): _____
Street City State Zip Code

Emergency Contact Information

Whom should we contact in case of an emergency? : _____ phone #: _____
Relationship to patient: _____

Financial Policy

As a condition of your treatment by this office, financial arrangements must be made in advance. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Insurance Assignment and Release
I _____ assign directly to Dr. David K. Dennison all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my minor/child's health care information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I have read the above conditions of treatment and payment and agree to their content.
_____ Date: _____
Signature of guarantor of payment/responsible party