Cypress Creek Family Dentistry
Christopher A. Hoppe, DDS

General Information

Patient Name:_____ Birthdate:_____ Male Female

Social Sec #:_____ Driver's License # / State:_____

Please circle one: Married Single Divorced Separated Widowed

Home Address:_____
Street Apt # City State Zip

Home Phone:_____ Alternate Phone (cell/pager):_____

Employer:_____ Occupation:_____

Employer's Address:_____

Work Phone:_____

Parent or Guardian Name if patient is a minor:_____

Emergency contact person:_____ Phone:_____

Dental Insurance Information

Insured's Name:_____Birthdate:_____

Insured's Soc. Sec. #:_____ Relationship to Patient:_____

Home Address (if different from above):_____
Street Apt. #

_____Phone:_____
City State Zip

Employer:_____ Occupation:_____

Employer's Address:_____

Work Phone:_____ Alternate Number (cell/pager):_____

Dental Insurance Co.*:_____Phone:_____

Group #:_____

Insurance Co. Address:_____

*We only file primary dental insurance

Referral Information

Whom may we thank for referring you to our practice?_____

Please circle one or more if applicable: Relative Another Patient Yellow Pages Dental Office
Physician Newspaper School Work Other:_____

Medical History

Name of Physician:_____ Phone:_____

Date of last exam:_____ Reason:_____

Are you in generally good health? Yes No If no, please explain:_____

Are you currently taking any medications, herbs, or supplements (vitamins)?_____

_____

Have you ever had any history of problems with the following?

Artificial Joints	Yes	No	Asthma	Yes	No
Bleeding Problems/Blood Disorders	Yes	No	Frequent ear/throat infections	Yes	No
Dizziness/Fainting	Yes	No	Seizures/Epilepsy	Yes	No
Glaucoma	Yes	No	Allergies	Yes	No
Frequent Headaches	Yes	No	Heart Problems	Yes	No
Radiation Treatment	Yes	No	Liver Problems/Hepatitis	Yes	No
Tuberculosis	Yes	No	Adverse reaction to drugs	Yes	No
Kidney Problems	Yes	No	Diabetes	Yes	No
Thyroid Problems	Yes	No	Cancer	Yes	No
Cerebral Palsy	Yes	No	Sinus Problems	Yes	No
Rheumatic Fever	Yes	No	Heart Murmur	Yes	No
Immune System Problems	Yes	No	Anemia	Yes	No
Tumors/Growths	Yes	No	Stomach Problems	Yes	No
Mental/Nervous Disorders	Yes	No	Respiratory/Breathing Problems	Yes	No
Pregnancy	Yes	No	Sleep Apnea	Yes	No
Due Date:_____			High Blood Pressure	Yes	No
Arthritis	Yes	No	Hay Fever	Yes	No
Head Injuries	Yes	No	Jaundice	Yes	No
Pacemaker	Yes	No	Rheumatism	Yes	No
Leukemia	Yes	No	Stroke	Yes	No
Ulcers	Yes	No	Venereal Disease	Yes	No

Any other problems not listed above?_____

Have you ever had a blood transfusion? Yes No If yes, under what circumstances?_____

_____

Have you ever been to the emergency room or been hospitalized? Yes No If yes, please explain:_____

_____

Do you smoke? Yes No Do you consume alcoholic beverages? Yes No

Herbal supplements can have clinically significant side effects, do you or have you recently used any herbal supplements? Yes No

If yes, please list_____

Dental History

Last visit to the dentist (date):_____ Dentist's Name:_____

Do you have any current dental problems? Yes No If yes, please explain:_____

_____

Do you have any concerns about the appearance of your teeth? Yes No If yes, please explain:_____

_____

Do you have anxiety about your dental appointments? Yes No If yes, please explain:_____

_____

History of injury to mouth, teeth, head? Yes No If yes, please explain:_____

_____

Have you ever had complications following dental treatment? Yes No If yes, please explain:_____

_____

Is there a family history of "soft teeth" or "bad teeth" or early loss of teeth? Yes No If yes, please explain:

_____

Do you brush daily? Yes No Number of brushings?_____ Floss Daily? Yes No

Purpose of today's dental visit?_____

Is there anything not listed above that you would like to discuss with the Doctor?_____

_____

_____

_____ Date:_____

Signature of patient/individual completing form

Consent for Treatment

State law requires us to obtain your written consent for dental treatment including examinations and cleanings.

I hereby authorize Cypress Creek Family Dentistry to perform dental treatment including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.

In general terms dental treatment may include:

A. Examination, cleaning of teeth and application of fluoride.

B. Taking digital photos, computerized shades, study models.

C. Application of plastic "sealants" to the grooves of the teeth.

D. Treatment of diseased (decayed) or injured teeth with dental restorations (fillings or crowns).

E. Treatment of diseased or injured oral tissues (hard and/or soft), including nerve treatment(s).

F. Removal (extraction) of one or more teeth.

G. Replacement of missing teeth with dental prosthesis.

H. Treatment of malposed (crooked) teeth.

I. Use of sedative drugs to control pain, gagging, and/or apprehension.

No guarantee is expressed or implied either as to result of dental treatment or as a cure.

State law requires us to inform you, the patient, of potential complications of dental treatment. Complications of dental treatment include: numbness, infection, swelling, bleeding, bruising, discoloration, nausea, vomiting, allergic or drug reactions, brain damage, stroke, heart attack, aspiration or swallowing of a foreign object, or scars. I further understand and accept that complications may require hospitalization and may even result in death.

I hereby state that I have read and understand this consent, and that this consent will remain in effect until such time that I choose to terminate it in writing.

_____ Date:_____

Signature of Patient/Guardian

_____ Date:_____

Signature of Dentist/Staff

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance need to understand that all dental services will be charged directly to the patient and that he/she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I agree that I am personally responsible for all dental treatment I receive and that I have a right to an estimate before any dental treatment begins.

_____ Date:_____

Signature of patient

_____ Date:_____

Signature of guarantor of payment/responsible party

Relationship to Patient:_____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

By signing below I acknowledge awareness of office Privacy Practices which are posted at the front desk and are available to me at my request.

_____

Please Print Name

_____

Signature

_____

Date