John N. Withers, DDS
3201 Teasley Ln. #101
Denton, TX 76210

PLEASE COMPLETE THE FOLLOWING :

Name: _____ Birth date: _____ Age: _____

Address: _____ City:_____ Zip: _____ Phone: (___) _____

Cell Phone: (___) _____ E-mail Address: _____

Employment – Self: _____ Business Phone :(___)_____

Physician: _____ Name of Spouse: _____

Employment – Spouse: _____Business Phone: (___)_____

Who may we thank for referring you to our office? _____

MEDICAL HISTORY - The following information is requested to thoroughly diagnose any relevant conditions and to give you our personal attention.

YES NO

___ ___ 1. Are you now, or have you been under a physician's care in the last five years?
___ ___ 2. Are you now taking any medication? This includes all over the counter drugs and oral contraceptives, as well as prescribed drugs. _____
___ ___ 3. Do you have any allergies or are you sensitive to any drugs such as penicillin, novocaine, aspirin, or codeine? _____
___ ___ 4. Do you bleed excessively after a cut, wound, or surgery?
___ ___ 5. Are you subject to fainting, dizziness, nervous disorders, convulsions, or epilepsy?
___ ___ 6. Have you ever had breathing difficulty, such as asthma, emphysema, chronic cough, pneumonia, T.B., or other lung diseases?
___ ___ 7. Have you ever had any of the following diseases or conditions such as heart problems/ prosthetic heart valve/ heart valve problems?
___ ___ 8. Rheumatic fever?
___ ___ 9. Hepatitis/liver or kidney disease?
___ ___ 10. High or Low blood pressure?
___ ___ 11. Prosthetic Joint ?
___ ___ 12. Diabetes?
___ ___ 13. Anemia?
___ ___ 14. Venereal Disease?
___ ___ 15. Any other infectious disease?
___ ___ 16. Tested positive for HIV?

DENTAL HISTORY:

1. Please comment about your previous dental experiences?
2. What is your main dental concern?
3. How do you feel about the appearance of your teeth?

Patient's Social Security #: _____ Driver's License #:_____

Name of Dental Insurance: _____ Insured's S.S. #: _____ Group #: _____

Person Responsible for Account:_____ Address: _____

***Any unpaid balance remaining after 60 days will be subject to a billing fee of 1.5% per month with a minimum fee of $5.00 per month.**

Signature: _____ Date: _____

(Please see reverse side)