PATIENT INFORMATION ADULT FORM

Patient Name:_____ Date of Birth:_____

Social Security #_____ TDL #_____

Mailing Address_____

City _____ State _____ Zip _____

Telephone: Home_____ Cell_____

E Mail Address:_____ (Used to Confirm appointment)

Employer Name:_____

Employer Address:_____

Employer Telephone:_____ Your position_____

Spouse Name:_____ Date of Birth:_____

Spouse Social Security #_____ TDL #_____

Spouse Cell:_____ Employer:_____

Employer Address: _____

Employer Telephone:_____ Job Position_____

Dental Insurance Company #1: _____

Telephone:_____ Group #_____

Insured Name:_____ ID#_____

Dental Insurance Company #2: _____

Telephone:_____ Group #_____

Insured Name:_____ ID#_____

Who may we contact in case of emergency? (Phone Number)_____

(Name)_____ (Relationship)_____

Do you have any medicine or Latex allergies? **Yes** **No**

List:_____

Do you take Pre Medication before dental work and why? _____

Have you ever taken or are you currently taking any blood thinners, i.e. Coumadin ? Yes No

List current medications you are taking: _____

_____

_____

Who referred you to our office? _____

(PLEASE COMPLETE OTHER SIDE)

MEDICAL HISTORY

Have you been under the care of a medical doctor during the past two years? Yes No

Have you been a patient in the hospital during the past two years? Yes No

Doctor Name:_____ Telephone Number:_____

Describe:_____

Are you currently taking any medication for Osteoporosis or Osteopenia? Yes No
Are you having dental pain or discomfort at this time? Yes No
Have you ever had a bad experience in the dental office? Yes No
Have you ever had a problem with anesthesia? Yes No
Have you ever been told you have gum disease or need deep cleaning (SRP)? Yes No
Do you use a C-PAP or any kind of sleeping device? Yes No
When was your last dental cleaning and x-rays? _____

Circle any of the following, which you have had or have at present:

Heart Failure/Attack	Emphysema	Hepatitis A (infectious)	Headaches
Heart Surgery	Asthma	Hepatitis B (serum)	Hay Fever
Irregular Heartbeat	Cough	Hepatitis C	Sinus Trouble
Heart Disease	Tuberculosis (TB)	Glaucoma	Allergies or Hives
Angina Pectoris	Stroke	Scarlet Fever	Cortisone or Steroids
Mitral Valve Prolapse	Kidney Trouble	Rheumatic Fever	Pain in Jaw Joints Arthritis
Heart Murmur	Rheumatism	Yellow Jaundice	Bruise Easily
Congenital Heart Lesions	Anemia	Liver Disease	Genital Herpes
High Blood Pressure	Ulcers	Epilepsy or Seizures	Syphilis
Low Blood Pressure	Thyroid Disease	Cold Sores	Gonorrhea
Heart Pacemaker	Diabetes	Fainting or Dizzy Spells	Alcoholism
Artificial Heart Valve	Artificial Joint	HIV Positive	Drug Addiction
Chemotherapy	Medical pins/ screws	Sickle Cell Disease	Psychiatric Treatment
X-ray/ Cobalt Treatment	Blood Transfusion	Hemophilia	Acquired Immune Deficiency Syndrome

11.) Do you smoke? How Much _____ Yes No

12.) WOMEN: Are you pregnant? Yes No
Are you nursing? Yes No
Are you taking oral contraceptives? Yes No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have a change in my health or medications I will inform the doctor of dentistry at the next appoint without fail. The undersigned hereby authorizes doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient=s dental needs. I also authorize doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with the patient and further authorize any consent that doctor chooses and employ such assistance as she deems fit. I also understand the use of anesthetic agents embodies a certain risk.

About Financial Arrangements and Dental Insurance

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility. Delay or failure of an insurance company to pay all or part of a claim is a matter that should be dealt with by the patient directly with the insurance company. The fees we charge for services rendered to those who are insured are our usual and customary fees charged to all patients for similar services. Your policy may base its allowances on a fixed fee schedule, which may or may not coincide with our usual fees. You should be aware that different insurance companies vary greatly in the type of coverage available. Unpaid claims by more than 60 days will then become due by the patient. The 60 days starts from the first day the charges were acquired, whether or not insurance has been filed. There is a $25.00 service charge for return checks and accounts with past due balances over 30 days.
I have read and agree with the above statement.

I have received a copy of this offices Right to Privacy Act.

_____

Signature of Patient or Guardian Date

Deborah Jo Gennero, D.D.S., F.A.G.D.

16225 Park Ten Place, Suite 695
Houston, Texas 77084
Telephone: (281) 578-6200

PHOTOGRAPHY CONSENT FORM / RELEASE

I,_____ , hereby grant permission to Deborah Jo Gennero, D.D.S., to take and use: photographs and/or digital images of me for use in website, news releases and/or educational materials. These materials might include printed or electronic publications, Web sites or other electronic communications. I further agree that my name and identity may be revealed in descriptive text or commentary in connection with the image(s). I authorize the use of these images without compensation to me. All negatives, prints, digital reproductions shall be the property of Deborah Jo Gennero, D.D.S.

_____
(Date)

_____
(Signature)

_____
(Address)

_____
(City, State, Zip)

RELEASE FOR MINOR CHILDREN (Under 18)
I,_____, parent or official guardian of:

_____
(Patient's Name)

hereby grant permission to Deborah Jo Gennero, D.D.S., to take and use: photographs and/or digital images of my child for use in news releases and/or educational materials as follows: printed publications or materials, electronic publications, or Web sites. I agree that my child=s name and identity: may be revealed in descriptive text or commentary in connection with the image(s). I authorize the use of these images without compensation to me. All negatives, prints, digital reproductions and shall be the property of Deborah Jo Gennero, D.D.S.

_____
(Date)

_____
(Signature of Parent or Guardian)

_____
(Address)

_____
(City, State, Zip)

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Telephone: (281) 578-6200

Esthetic Evaluation

Name_____ Date_____

Hold a full facial mirror 12-14" from your face. Smile to show your teeth. Take a look at your teeth carefully, and then answer the following questions.

Do you like the overall appearance of your teeth, your smile?
[ ] Yes [ ] No
If NO, please describe_____

Do you consider that your teeth are in good alignment (straight)?
[ ] Yes [ ] No
If NO, please describe_____

Do you have spaces between your teeth that you don't like?
[ ] Yes [ ] No
If YES, please describe_____

Do you like the color of your teeth?
[ ] Yes [ ] No

Are you interested in teeth whitening?
[ ] Yes [ ] No

Do your teeth have unattractive stains?
[ ] Yes [ ] No

[ ] Tobacco stains [ ] Silver filling stains [ ] Coffee/Tea stains
[ ] Discolored fillings [ ] Tetracycline stains [ ]

Other_____

Do you like the shape of your teeth?
[ ] Yes [ ] No
If NO, please describe_____

Do you think that your teeth are attractive? [ ] Yes [ ] No

[ ] Chipped [ ] Hidden [ ] Overlapping
[ ] Protruding [ ] excessively worn [ ] Artificial looking

Do you like the way your upper and lower teeth come together?
[ ] Yes [ ] No
If NO, please describe_____

Do you consider your existing fillings or dental work as unattractive? [ ] Yes [ ] No
If YES, please describe_____

Do you think your gums are unattractive? [ ] Yes [ ] No

[ ] Swollen [ ] Bleed easily [ ] excessively receded
[ ] Reddened [ ] Crowns are ill-fitting [ ] Difficult to clean between teeth

What would you like to change the most about the appearance of your teeth, your smile? _____
_____