

Favour Dental
5403 FM 1488 Suite A7
Magnolia, TX 77354
(281) 259-6717

*Thank you for trusting us with your dental care.
We promise to do our best to provide you with
the finest care available. If you have any
questions please do not hesitate to call us.*

Patient # _____

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ SS# _____

Address _____ City _____ State _____ Zip _____

Sex ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years

Home Phone _____ Cell Phone _____ Email _____

Employer _____ Employer Phone _____

Employer Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

RESPONSIBLE PARTY

Name of Person
Responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone _____

Birthdate _____ Currently a patient in our office? ☐ Yes ☐ No

Employer _____ Work Phone _____

E-Mail _____ Cell Phone _____

DENTAL INSURANCE INFORMATION

Name of Insured _____ Relation to Subscriber _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone # _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Subscriber ID _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

ADDITIONAL DENTAL INSURANCE

Name of Insured _____ Relation to Subscriber _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone # _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Subscriber ID _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Check (✓) if you have or have had problems with any of the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Sensitivity to Heat |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Loose Teeth or Broken Fillings | <input type="checkbox"/> Sensitivity to Sweets |
| <input type="checkbox"/> Clicking or Popping Jaw | <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> Sensitivity When Biting |
| <input type="checkbox"/> Food Collecting Between the Teeth | <input type="checkbox"/> Sensitivity to Cold | <input type="checkbox"/> Sores or Growths in Mouth |

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name and Contact Number: _____ Date of last visit: _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you ever had any serious illnesses or operations?? ☐ Yes ☐ No *If yes, describe:* _____

Are you Taking Blood Thinners? ☐ Yes ☐ No *If yes: Type:* _____ *Dosage:* _____

Do you have Artificial Heart Valves or Stints? ☐ Yes ☐ No *If yes, When (Month and Year):* _____

Do you have Artificial Joints or Replacements? ☐ Yes ☐ No *If yes, When (Month and Year):* _____

If Yes, what was replaced? _____ *Metal / Mesh / Plastic Other:* _____

(Women) Are you pregnant? ☐ Yes ☐ No *If Yes, How many weeks/trimester?* _____

Check (✓) if you have or have had problems with any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Congenital Heart lesions | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joints, Pins, etc. | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bleeding Abnormally | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> NONE |

List medications you are currently taking:

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Allergies:

- | | | | |
|---|----------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Amoxicillin / Penicillin | <input type="checkbox"/> Clove | <input type="checkbox"/> Latex | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Local Anesthetic: | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Clindamycin | <input type="checkbox"/> Iodine | <i>Type:</i> _____ | <input type="checkbox"/> None |

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my mindor child, ever have a change in health.

Signature of of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.