

D.A. DOCKINS, D.D.S.

2758 N. Galloway
Suite 300

Mesquite, Texas 75150
972-289-5563

PERSONAL INFORMATION

This personal information will help us to give you the most consideration of your time and feelings.
All information is, of course, confidential.

Patient's Name _____

Responsible Party _____ (Father, Mother, Spouse, Self)

Home Address _____ City/Zip _____

Home Number _____ Cell # _____ Wk# & Ext. _____ Marital Status _____

DL # _____ Social Security# _____ DOB _____ Sex _____

Email Address _____

Has anyone from your immediate family been a patient at this office before? _____ yes _____ no.

If so who? _____ Referred by? _____

Does your family have dental insurance? _____ yes _____ no. (Info. of Policy Holder)

If so, _____ company _____ group# _____ policy holder _____

SS# _____ ID# _____ DOB _____

Place of Business _____

Business Address _____

Nearest relative not living in the same household: _____

Name _____ Relationship _____

Address _____ Phone _____

HEALTH HISTORY

Has there been any problems in your general health within the past 5 years? _____ (Serious illness, hospitalization, surgery)

If so, what was the problem? _____

The date of your last medical check-up _____ Are you under a physician's care now? _____

If so, for what? _____ Date of last dental visit _____

What tablets, pills, or liquids do you take (including aspirin, vitamins, tonics, etc.) _____

Your Physician's Name _____ Phone # _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS:

	Yes	No		Yes	No
Rheumatic fever, rheumatic heart disease	___	___	Diabetes	___	___
Heart trouble, heart attack, high blood pressure, stroke	___	___	Radiation treatment for tumor/growth	___	___
Blood Thinners	___	___	Sores that did not heal within one week	___	___
Pain in chest, shortness of breath, swollen ankles	___	___	Do you smoke or use tobacco products?	___	___
Blood disorders, anemia	___	___	Venereal disease, AIDS, HIV	___	___
Blood test with an unusual result	___	___	Women: Are you pregnant?	___	___
Abnormal bleeding, prolonged healing, bruises easily	___	___	Sensitive or allergic to penicillin	___	___
Asthma, hay fever	___	___	Codeine ___ Novocaine ___ Aspirin ___	___	___
Low blood pressure	___	___	Anesthetics ___ Other drugs ___	___	___
Fainting spells, seizures	___	___	Do you have any disease, condition or problem not listed above that you think the doctor should know about?	___	___
Hepatitis, jaundice, liver diseases	___	___			
Arthritis	___	___			
Kidney problems	___	___			
Tuberculosis, other lung ailments	___	___			
Persistent cough, cough up blood	___	___			
Artificial Joints, Stints	___	___			

_____ Date _____ Patient's Signature

_____ If under 18 - Signature of Responsible Party(s)