Dr. Diana Raulston

Welcome to Our Practice!

Patient Name_____ Today's Date_____
First MI. Last

Email_____

Address_____ Apt. No._____

City_____ State_____ Zip_____

Social Security_____ DOB_____ Male_____ Female_____ Marital Status_____

Home Phone_____ Bus. Phone_____ Cell Phone_____

Employer_____ Occupation_____ Drivers License No._____

Spouse's Name_____ Employer_____ Business Phone_____

Spouse's SS No._____ Spouse's Birth Date_____

Dental Insurance Company_____

Address_____ Phone_____

Policy Number_____ Group Number_____

Policyholder Name_____ Relationship_____ DOB_____

Whom May We Thank for Referring You?_____

Insurance Benefits:

As part of our service to our patients, we will help you in filing for insurance benefits. If you have Secondary Insurance, we ask that you file it. We will be glad to help you any way we can.

At the time of service, we request that you pay your out of pocket expenses (insurance deductibles and coypayments). If your insurance company does not pay within 60 days, you will need to pay the balance. In Texas, doctor's offices are considered third parties to insurance benefits and are not allowed to contest payments. Only the patient can dispute insurance benefits.

Since every insurance carrier has a different fee schedule, we can only estimate your benefits and your out of pocket expenses. Sometimes insurance pays less or none of the charges. In these cases, you will be responsible for the charges.

We always try to run on time so if you need to change an appointment please give us 24 hours notice. There will be a charge for cancellations without 24 hours notice.

MEDICAL HISTORY FORM

Date of last visit _____ Are you having discomfort now? _____

Patient's Physcian _____ Physician's phone no. _____ Last visit _____

1. Are you under the care of a physician now? _____
2. Are you taking any drugs or medications? Please list _____

_____

3. Have you ever been premedicated with an antibiotic before dental appointment? _____
4. Are you allergic to any drugs or medications? _____
5. Do you have a family history of diabetes? _____
6. Have you ever taken Bisophosphates? _____
   a. Fosamax Yes ___ No___
   b. Boneva Yes ___ No___
   c. Reclast Yes___ No___
7. a. Have you ever had excessive bleeding requiring special treatment? _____
   b. Women: Are you on birth control? Yes ___ No___
   Nursing? Yes___ No___
   Pregnant? Yes___ No___
   Do you anticipate becoming pregnant? Yes ___ No___
8. Do you use tobacco products? If yes, list _____
9. Are you interested in bleaching/whitening your teeth? _____

MEDICAL HISTORY

Do you have or have you ever had any of the following:

			When				When
Artificial Joint	Yes	No		Osteoporosis	Yes	No	
Heart Trouble	Yes	No		Eating Disorders	Yes	No	
Heart Murmur	Yes	No		High Blood Sugar	Yes	No	
Congential Heart Disease	Yes	No		Low Blood Sugar	Yes	No	
Rheumatic Fever	Yes	No		Excessive Thirst	Yes	No	
Chest Pain	Yes	No		Excessive Urination	Yes	No	
Abnormal Blood Pressure	Yes	No		Urinating Problems	Yes	No	
Swelling of Ankles	Yes	No		Kidney Problems	Yes	No	
Shortness of Breath	Yes	No		Anemia	Yes	No	
Pneumonia	Yes	No		Hemophilia	Yes	No	
Tuberculosis	Yes	No		Other Blood Disorder	Yes	No	
Other Lung Disease	Yes	No		Epilepsy or Seizures	Yes	No	
Asthma	Yes	No		Stroke	Yes	No	
Chronic Cough	Yes	No		Nervousness	Yes	No	
Emphysema	Yes	No		Thyroid Problems	Yes	No	
Sinus Trouble	Yes	No		Back Pains	Yes	No	
Faint Easily	Yes	No		Arthritis	Yes	No	
Ulcers	Yes	No		Glaucoma	Yes	No	
Jaundice	Yes	No		AIDS/HIV	Yes	No	
Hepatitis A (infectious) B (serum) or C	Yes	No		AIDS Related Complex	Yes	No	
Other Liver Disease	Yes	No		Blood Transfusion	Yes	No	
Diabetes	Yes	No		Alcohol/Drug Abuse	Yes	No	
Tumor or Cancer	Yes	No		Genital Herpes	Yes	No	
Chemotherapy/Radiation	Yes	No		Smallpox or Smallpox Vaccine	Yes	No	
If yes, IV	Yes	No		Scarlet Fever	Yes	No	
Bisphosphonates	Yes	No		Psychiatric Txt.	Yes	No	
Cortisone Medicine	Yes	No		Cold Sores	Yes	No	
				Specific Herbs	Yes	No	

PLEASE PROVIDE RECEPTIONIST WITH YOUR INSURANCE I.D. CARD AND DRIVER'S LICENSE

I hereby certify that I have answered the above questions correctly. By my signature I also certify that I accept full responsibility for the professional fees incurred.

Print Name _____

Signature of Patient, Parent or Guardian _____ Date _____