Robert Lee Bishop, DDS
5200 Cedar Street
Bellaire, TX 77401

DATE ____________

PATIENT NAME ____________ DATE OF BIRTH ____________

MAILING ADDRESS ____________

CITY STATE ZIP

EMAIL ____________

HOME PHONE ____________ WORK PHONE ____________ CELL PHONE ____________

☐ MALE ☐ FEMALE

☐ SINGLE ☐ MARRIED - NAME OF SPOUSE ____________ # OF DEPENDENTS ____________

SOCIAL SECURITY # ____________ PARENT'S NAME (IF CHILD) ____________

EMPLOYER ____________ OCCUPATION ____________

EMERGENCY CONTACT:

NAME ____________

ADDRESS ____________

____

PHONE ____________

RELATIONSHIP TO PATIENT ____________

RESPONSIBLE PARTY:

NAME ____________

ADDRESS ____________

____

PHONE ____________

RELATIONSHIP TO PATIENT ____________

WHO REFERRED YOU TO OUR OFFICE? ____________

DENTAL INSURANCE:

NAME ____________

POLICY # ____________

GROUP # ____________

WHAT ARE YOUR SPECIFIC DENTAL NEEDS?

1. ____________
2. ____________
3. ____________

WHEN WAS YOUR LAST DENTAL EXAM? ____________

WHEN WAS YOUR LAST TEETH CLEANING? ____________

HOW OFTEN DO YOU BRUSH YOUR TEETH? ____________

HOW OFTEN DO YOU FLOSS YOUR TEETH? ____________

	YES	NO
DO YOUR GUMS BLEED WHILE FLOSSING?	☐	☐
DO YOUR GUMS FEEL TENDER OR SWOLLEN?	☐	☐
DO YOU GET COLD SORES OR FEVER BLISTERS?	☐	☐
HAVE YOU EVER HAD PERIODONTAL (GUM) TREATMENT?	☐	☐
DOES FOOD CATCH BETWEEN YOUR TEETH?	☐	☐
ARE TEETH SENSITIVE TO HEAT, COLD, SWEETS?	☐	☐

	YES	NO
DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
HAVE YOU HAD DIFFICULT EXTRACTIONS IN PAST?	☐	☐
HAVE YOU HAD PROBLEMS WITH DENTAL ANESTHETICS?	☐	☐
ARE YOU ALLERGIC TO PENICILLIN?	☐	☐
ARE YOU ALLERGIC TO CODEINE?	☐	☐
ARE YOU ALLERGIC TO LATEX?	☐	☐
ARE YOU ALLERGIC TO DENTAL ANESTHESIA?	☐	☐

PLEASE LIST ALL THE ALLERGIES THAT YOU HAVE:

YES	NO	
1. HAVE YOU HAD A SERIOUS ILLNESS OR SURGERY IN THE PAST 2 YEARS?	☐	☐
2. ARE YOU CURRENTLY UNDER MEDICAL TREATMENT?	☐	☐

IF YES TO THE ABOVE QUESTIONS, EXPLAIN

LIST ALL MEDICATIONS CURRENTLY TAKING:

NAME	QUANTITY	REASON

PLEASE CHECK ALL THAT APPLY:

- ☐ ALLERGIES OR HIVES
- ☐ ANEMIA
- ☐ ARTHRITIS
- ☐ ARTIFICIAL HEART VALVE
- ☐ ASTHMA
- ☐ ARTIFICIAL JOINTS OR IMPLANT (HIP, KNEE, ETC.)
- ☐ BLOOD THINNERS OR DAILY ASPIRIN
- ☐ BLOOD TRANSFUSION
- ☐ BRUISE EASILY
- ☐ CANCER / TUMORS
- ☐ CHEMOTHERAPY
- ☐ PERSISTENT COUGH
- ☐ DIABETES
- ☐ DRUG / ALCOHOL ADDICTION
- ☐ EPILEPSY / SEIZURES
- ☐ FAINTING OR DIZZY SPELLS
- ☐ FREQUENT THIRST / URINATION
- ☐ GLAUCOMA
- ☐ HAY FEVER / SINUS PROBLEMS
- ☐ HEART ATTACK
- ☐ HEART DISEASE
- ☐ HEART MURMUR
- ☐ HEART SURGERY
- ☐ HEART PROBLEMS
- ☐ CONGENITAL HEART DEFECTS / LESIONS
- ☐ HEMOPHILIA (ABNORMAL BLEEDING)
- ☐ HIGH BLOOD PRESSURE
- ☐ LOW BLOOD PRESSURE
- ☐ LIVER DISEASE
- ☐ HEPATITIS A B C (CIRCLE ONE)
- ☐ JAUNDICE
- ☐ KIDNEY / BLADDER PROBLEMS
- ☐ HIV POSITIVE
- ☐ AIDS
- ☐ NERVOUS PROBLEMS
- ☐ PACEMAKER
- ☐ PSYCHIATRIC CARE
- ☐ RADIATION TREATMENT
- ☐ RHEUMATIC FEVER
- ☐ SCARLET FEVER
- ☐ SHORTNESS OF BREATH
- ☐ SICKLE CELL DISEASE
- ☐ DO YOU SMOKE?
- ☐ THYROID DISEASE
- ☐ TUBERCULOSIS
- ☐ ULCERS
- ☐ VENEREAL DISEASE

PLEASE USE THE SPACE BELOW FOR ANY ADDITIONAL COMMENTS:

PATIENT SIGNATURE ______________________ DATE ______________

DOCTOR SIGNATURE ______________________ DATE ______________

MEDICAL HISTORY UPDATE (INITIAL ONLY)

PATIENT	DATE	DOCTOR	DATE