DR. TRAVIS G. HAMMONS

10740 Research Blvd. Suite #125
Austin, Texas 78759

PATIENT REGISTRATION

Patient's Name **Birth date** **Age** **Sex: M F**

Home Address	**City**	**State**	**Zip**
Home Phone # **Work Phone #** **YOUR cell phone #**	***Please Circle One:*** Single, Married, Separated, Widow		**Your Soc Sec. # (is not necessary if paying at the time of service)**
Your Employer			
Occupation			

Are you a full time student? ☐Yes ☐ No

If patient is minor we will need: *Mother's Name & Birth date* *Father's Name & Birth date*

Person paying this bill **YOUR Driver's License Number**

Name of spouse (or parent if minor) **YOUR E-mail address**

Spouse's (or parent's) employer **Spouse's Soc. Sec. #** **Work phone #**

EMERGENCY INFORMATION

Name, Address, & Telephone of A relative not living with you:

How did you hear about our office?

Reason for your visit today?

DENTAL INSURANCE INFORMATION (Primary Carrier)	**If you have a dual insurance coverage, complete this for the second coverage (this office bills primary ins only)**
Insured's name DOB SS#	Insured's name DOB SS#
Insured's employer	Insured's employer
Insurance Co	Insurance Co
Insurance Co Address	Insurance Co Address
Phone #	Phone #
Group # Policy #	Group # Local #

Patient Signature (or Parent of Child) **Date** **Dentist's Signature**

DENTAL HISTORY

Please check the following :	YES	NO
-Sensitivity (hot, cold, sweet) Where? UR LR UL LL	☐	☐
-Headaches, ear aches, neck or jaw joint pain	☐	☐
-Mouth ulcers or cold sores	☐	☐
-Teeth or fillings breaking	☐	☐
-Grinding or clenching teeth	☐	☐
-Bleeding, swollen or irritated gums	☐	☐
-Loose, tipped or shifting teeth	☐	
-Bad breath	☐	☐
Do you have or have you had any of the following?		☐
-Dentures	☐	☐
-Partial dentures	☐	☐
-Braces	☐	☐
-Gum treatments	☐	☐

Please share the following dates:

-Your last cleaning ___ / ___

-Your last oral cancer screening ___ / ___

-Your last complete X-Rays ___ / ___

Name of Previous Dentist _____

City _____ **State** _____

Phone Number _____

What is the most important thing to you about your future smile and dental health? _____

	YES	NO
If you could whiten your teeth for a cost anyone could afford, would you do it?	☐	☐
Do you smoke or use chewing tobacco? How much? For how long?	☐	☐
If I could change my smile, I would:	☐	☐
-Make my teeth whiter	☐	☐
-Make my teeth straighter	☐	☐
-Close spaces	☐	☐
-Replace metal fillings with tooth colored restorations	☐	☐
-Repair chipped teeth	☐	☐
-Replace missing teeth	☐	☐
-Replace old crowns that don't match	☐	
-Have a smile makeover	☐	☐

On a scale of 1 – 10, with 10 being the highest rating:

-How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

-Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

_____

_____

What is the most important thing to you about your dental visit today? _____

MEDICAL HISTORY

Please check any of the following that apply to you:

☐ Allergies (Seasonal)	☐ Excessive Bleeding	☐ Nervousness/Depression	☐ Ulcers
☐ Anemia	☐ Glaucoma	☐ Pacemaker	☐ OTHER (please list):
☐ Artificial Heart Valve	☐ Heart Conditions	☐ Phen Fen (1 month +)	_____
☐ Artificial Joints	☐ Heart Murmur	☐ Radiation (head/neck)	_____
☐ Asthma	☐ Hepatitis A	☐ Respiratory Problems	_____
☐ Blood Disease	☐ Hepatitis B	☐ Rheumatic Fever	_____
☐ Bruise Easily	☐ Hepatitis C	☐ Rheumatism	_____
☐ Cancer	☐ High Blood Pressure	☐ Scarlet Fever	_____
☐ Chemotherapy	☐ HIV/AIDS	☐ Seizures	**For WOMEN Only**
☐ Diabetes	☐ Jaundice	☐ Stomach Problems	❑ Birth Control Pills
☐ Dizziness/Fainting	☐ Kidney Disease	☐ Stroke	❑ Breast-feeding
☐ Drug Addiction	☐ Liver Disease	☐ Thyroid Disease	❑ Pregnant
☐ Emphysema	☐ Mitral Valve Prolapse	☐ Tuberculosis	1-3 mos,3-6 mos,6-9mos,

Do you have an allergy to any of the following?

☐ Aspirin	☐ Codeine	**What medications are you currently taking?**
☐ Erythromycin	☐ Other: _____	
☐ Latex		
☐ Local Anesthetic	_____	_____
☐ Nitrous Oxide	_____	_____
☐ Penicillin	_____	_____

Are you under a physician's care? For what?

_____

_____

Family Physician	**Phone Number**
_____	_____

Is there any other Medical or Dental Information **We Should Know About?**

_____ _ _____ _____ _____ _____