TYLER HEADACHE CENTER

HEADACHES • MIGRAINES • TMJ/TMD • FACE PAIN • CHRONIC TENSION

17789 FM 344W | Flint, TX 75762 | (903) 825-1112

❖ Patient Information

Name (Last, First MI): _____ Birthdate: ____/____/____
I prefer to be called: _____ E-mail: _____
Street Portion of Mailing Address: _____
City, State: _____ Zip Code: _____ Home #_____
Employer: _____ Work #_____ Mobile #_____
Location of Employer (City & State): _____ Occupation: _____
Social Security #_____ Driver License #_____ State: _____
Marital Status (check one): □ Single □ Married □ Separated □ Divorced □ Widowed □ Other
Spouse's Name (Last, First MI): _____ Birthdate: ____/____/____
Spouse's Employer: _____ Work #_____
Emergency Contact (Name and Telephone): _____

❖ Head of Household Information

Name of Person Responsible for Account (Last, First MI): _____
Birthdate: ____/____/____ Social Security #_____ Relationship to Patient: _____
Street Portion of Mailing Address (if different): _____
City, State: _____ Zip Code: _____ Home #_____
Employer: _____ Work #_____ Mobile #_____
Location of Employer (City & State): _____ Driver License #_____ State: _____

❖ Insurance Information

Do you currently have dental insurance? □ Yes □ No (**If yes, please complete this section)
Subscriber Name (Last, First MI): _____
Subscriber Birthdate: ___/___/___ Social Security #_____ Relationship to Patient: _____
Insurance Company: _____ Telephone #_____
Employer: _____ Group #_____

❖ Medical History

Have you ever had or do you currently have any of the following? (please check all that apply)

□ Asthma	□ High Blood Pressure	□ Ulcers
□ Arthritis	□ Heart Murmur	□ Stroke
□ Artificial Joints	□ Heart Disease	□ Pacemaker
□ Anxiety/Nervous Disorder	□ Heart Attack	□ Rheumatic Fever
□ Alcohol/Drug Addiction	□ Mitral Valve Prolapse	□ Tuberculosis
□ Blood Transfusion	□ Glaucoma	□ Respiratory Problems
□ Back/Neck Problems	□ Hemophilia/Excessive Bleeding	□ Sinus Problems
□ Cosmetic Surgery	□ Hepatitis, Type ___	□ Stomach Problems
□ Cancer/Chemotherapy	□ HIV/AIDS Test Positive	□ Kidney Disease
□ Diabetes	□ Herpes/Cold Sores	□ Liver Disease
□ Epilepsy/Seizures	□ Head Injury/Mental Disorder	□ Thyroid Disease
□ Fainting/Dizziness	□ Headaches/Migraines	□ Venereal Disease

Please list any other conditions not listed above: _____

Are you allergic or have you ever reacted adversely to any of the following? (please check all that apply)

□ Aspirin	□ Erythromycin	□ Nitrous Oxide	□ Sulfa Drugs
□ Codeine	□ Latex	□ Penicillin	□ Tetracycline
□ Epinephrine	□ Local Anesthetic	□ Hydrocodone	□ Valium

Please list any other allergies not listed above: _____

Do you smoke or chew tobacco? □ Yes □ No **If yes, how much? _____
Physician's Name: _____ Telephone #_____
Date of Last Physical Examination: ____/____/____ Are you currently taking medication? □ Yes □ No
**If yes, please list: _____
Have you been hospitalized in the past two years? □ Yes □ No
**If yes, for what reason? _____
Are you currently under the care of a physician for a specific condition? □ Yes □ No
**If yes, please describe: _____

FOR WOMEN

Are you pregnant? □ Yes □ No **If yes, how many months? _____
Are you taking birth control pills? □ Yes □ No

❖ Dental History

Name of Previous/Present Dentist: _____ Date of Last Visit: _____
Location of this Dentist (City & State): _____ Telephone #_____
**Is there anything particular that you liked or disliked about your previous dentist or his office?
_____
How did you hear about us? (friend, yellow pages, sign, etc.) _____
How many times a day do you brush your teeth? _____ How often do you floss? _____
Are you currently in dental-related pain? □ Yes □ No Do you frequently experience jaw pain? □ Yes □ No
Do you have difficulty becoming numb for dental treatment? □ Yes □ No □ Unsure
Do you have dental-related anxiety? □ Yes □ No
Are you happy with the appearance of your smile? □ Yes □ No
**If no, please tell us what you would like to change (color, shape, alignment, etc.): _____
_____

Please number the following in the order in which each would keep you from having dental treatment:
__ Fear of pain __ Cost of treatment __ Lack of concern __ Missing work time

❖ Consent for Treatment

The undersigned, (print name) _____, hereby confirms that the above information is correct to the best of his/her knowledge. I understand that the information given will be used by the doctor to help determine appropriate and healthful dental treatment for this patient. If there is any change in this patient's medical status, I agree to inform the dentist or a member of his staff. Furthermore, I authorize the doctor to take x-rays, photographs, study models, and/or any other diagnostic aids he deems appropriate in order to make a thorough diagnosis of this patient's dental needs. I also authorize the doctor to choose and employ such assistance as he deems fit. I give my consent for the doctor to use any and all forms of treatment and therapy necessary, including prescribing or administering medications that may be indicated in connection with this patient, to be determined and discussed on an appointment-to-appointment basis. I understand that the use of anesthetic agents embodies a certain risk.

_____ _____
Patient Signature (Parent or Guardian Signature) Date