David Gluckman, D.D.S.
FAMILY & COSMETIC DENTISTRY

WELCOME TO OUR PRACTICE!

Thank you for selecting our dental healthcare team. **Please fill out this form completely front and back.** If you have any questions or concerns, please do not hesitate to ask for assistance — we will be glad to help.

Date_____ DL# _____ Social Security # _____

Patient Name _____ Birthdate _____

Address _____ City _____ State ___ Zip _____

Home Phone _____ Work _____ Mobile _____

Sex M F Minor_____ Single____ Married ___ Divorced____ Widowed __

Your Employer _____ Occupation _____

Responsible Party _____ Relationship to Patient _____

Insurance Company Name _____

Whom may we thank for referring you? _____

Emergency Contact Name & Phone # _____

If you are a student, name of school/college _____

AUTHORIZATION, RELEASE AND AGREEMENT TO PAY FOR SERVICES

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payors and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist the insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf, or on behalf of my dependents.

Signature _____ **Date** _____
Patient, Parent or Guardian

Email Address _____

3818 Far West Blvd., Suite 111 • Austin, Texas 78731 • (512) 345-1140 • Fax (512) 345-1986

PATIENT MEDICAL HISTORY

Physician Name & Phone # _____

Yes No

❒ ❒ Under medical treatment now?
❒ ❒ Taking any medication(s)?

If yes, what medications are you taking?

_____

_____

❒ ❒ (Women)-Pregnant/Possibly

Yes No

❒ ❒ Do you use tobacco?
❒ ❒ Allergies to medication(s)?

If yes, which? _____?

_____

❒ ❒ Use of alcohol, cocaine, or other drugs?

Do you have, or have you had any of the following?

Yes No

❒ ❒ Frequent and severe headaches
❒ ❒ Heart Attack
❒ ❒ Rheumatic Fever
❒ ❒ Arthritis
❒ ❒ Fainting/Seizures
❒ ❒ Asthma
❒ ❒ Low/High Blood Pressure
❒ ❒ Epilepsy/Convulsions
❒ ❒ Leukemia
❒ ❒ Diabetes
❒ ❒ Kidney Disease
❒ ❒ AIDS or HIV Infection
❒ ❒ Thyroid Condition

Yes No

❒ ❒ Heart Disease
❒ ❒ Cancer
❒ ❒ Stroke
❒ ❒ Hay Fever/Allergies
❒ ❒ Tuberculosis
❒ ❒ Radiation Therapy
❒ ❒ Glaucoma
❒ ❒ Hepatitis
❒ ❒ Heart Murmur
❒ ❒ Mitral Valve Prolapse
❒ ❒ Respiratory Problems
❒ ❒ Joint Replacement/Implant
❒ ❒ Other_____

PATIENT DENTAL HISTORY

Yes No

❒ ❒ Gums bleed while brushing/flossing?
❒ ❒ Are your teeth sensitive to hot or cold?
❒ ❒ Do you feel pain on any tooth?
❒ ❒ Sores or lumps near or in mouth?
❒ ❒ Past head, neck, or jaw injuries?
❒ ❒ Problems in Jaw:
  ❒ Clicking?
  ❒ Pain (joint, ear, side of face)?
  ❒ Difficulty in opening or closing?
  ❒ Difficulty in chewing?

Yes No

❒ ❒ Do you clench/grind teeth?
❒ ❒ Do you bite lips/cheeks frequently?
❒ ❒ Difficult extractions in the past?
❒ ❒ Past orthodontic treatment?
❒ ❒ Have you ever been told you have gum disease?
❒ ❒ Have you ever had periodontal treatment?

Comments:_____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature _____ **Date** _____

Patient, Parent, or Guardian