*John Shoemaker, D.D.S., D.I.C.O.I. *1609 N HWY 75, Suite 300* Sherman, TX 75092*(903) 893-7751*

Date:___________________________
Name:_______________________________________Date of Birth:_____________SS#:__________________Sex:_____
Address:_____________________________________City/State:______________________Zip Code:________________
Home #:______________________________Work #:________________________Cell #:__________________________
Email:____Facebook: O Yes O No Text: O Yes O No
Employer:____Phone#:____
Marital Status: Single Married Divorced Widow Referred By:_______________________________________
Spouse Name:________________________________Date of Birth:_____________SS#:______________Sex:_________
Home #:______________________________Work #:________________________Cell #:__________________________
Employer:____Phone#:____
Person Financially Responsible:____________________________________Relation to You:______________________
Should an emergency arise, who would you like for us to contact:
Name:________________________________Phone#:________________________Relation:_______________________

DENTAL INSURANCE

Name of Subscriber:________________________________Date of Birth:_____________SS#:______________________
Employer:____Phone#:____
Insurance Name:____________________________________Member ID#:_____________________________________
Group#____Phone#:____
Claim Address:_______________________________City/State:____________________________Zip Code:___________
If patient is over the age of 18; please list school name attending:____
How many hours taking:_________________What semester patient is in:_________________________________

Initial

_____Most dental insurance plans do not cover 100% of the cost of your treatment. Because of this, you will be asked to pay your portion of the services rendered on the day of treatment.

_____Non-insured patients are expected to pay in full the day of services rendered by cash, check or credit card; unless financial arrangements are made in advance.

DENTAL & MEDICAL HISTORY

General Health O Excellent O Good O Fair O Poor
Have there been any changes in your general health in the past year? O Yes O No
If yes, explain:____
My last physical exam was:______________Physician:_____________________________Phone:__________________
Are you now under a care of a physician? O Yes O No If yes, for what?__________________________________
Preferred Pharmacy:____ Phone:______________________________

DO ANY OF THE FOLLOWING APPLY TO YOU?

Have you ever had a hip or joint replacement? O YES O NO WHEN?______________________________________
Have you ever had a Rheumatic Fever or Rheumatic Heart Disease? ______________________________O Yes O No
Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma?________O Yes O No
Have you ever had a blood transfusion?____O Yes O No
Have you ever had any major surgery, hospitalization or x-ray treatment?___________________________O Yes O No
Are you employed in any situation, which exposes you regularly to x-rays or ionizing radiation?_______O Yes O No
Have you ever had any serious trouble associated with dental treatment?____________________________O Yes O No
Have you ever had dental implants placed?____O Yes O No
Have you traveled outside of the USA in the past year? ____If so where?_______________________When?_________
Have you ever had any type of cancer? If so what type?___________________Chemo?________Radiation?________
Do you smoke? ___________________ Use tobacco? ______________________ Drink alcohol? _____________________

DO YOU WEAR ANY OF THE FOLLOWING?

Contact Lenses	O Yes O No	Hearing aid	O Yes O No
Pacemaker	O Yes O No	Insulin Pump	O Yes O No

WOMEN

Are you pregnant?____O Yes O No If so, how far along?________

Do you have any problems with your menstrual cycle?________________O Yes O No

DO YOU HAVE ANY OF THE FOLLOWING DISEASES OR PROBLEMS:

ANEMIA	YES	NO	HERPES	YES	NO
ARTHRITIS	YES	NO	HIGH BLOOD PRESSURE	YES	NO
ASTHMA	YES	NO	HIV OR AIDS	YES	NO
CANDIDA	YES	NO	HIVES OR SKIN RASH	YES	NO
CONGENITAL HEART LESIONS	YES	NO	INFLAMMATORY RHEUMATISM	YES	NO
DIABETES-TYPE ____ A1C ____	YES	NO	KIDNEY PROBLEMS	YES	NO
EPILEPSY/SEIZURES	YES	NO	LOW BLOOD PRESSURE	YES	NO
EPSTEIN-BARR	YES	NO	MULTIPLE SCLEROSIS	YES	NO
FAINTING SPELLS	YES	NO	PERSISTENT COUGH	YES	NO
GLAUCOMA	YES	NO	SCARLET FEVER	YES	NO
HEAD INJURIES	YES	NO	SLEEP APNEA/SNORE	YES	NO
HEARING	YES	NO	STOMACH ULCERS	YES	NO
HEART DISEASE/ATTACK	YES	NO	STROKE	YES	NO
HEPATITIS A	YES	NO	THYROID DISEASE	YES	NO
HEPATITIS B	YES	NO	TUBERCULOSIS-CLEAR X-RAY	YES	NO
HEPATITIS C	YES	NO	VENEREAL DISEASE	YES	NO

ALLERGIES – ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO:

ACETAMINOPHEN	YES	NO	IODINE	YES	NO
ASPIRIN	YES	NO	LATEX	YES	NO
BARBITUATES	YES	NO	LOCAL ANESTHETIC	YES	NO
CODEINE	YES	NO	PENICILLIN	YES	NO
EPINEPHRINE	YES	NO	SEDATIVES	YES	NO
ERTHROMYCIN	YES	NO	SULFA	YES	NO
HALCION	YES	NO	TETRACYCLINE	YES	NO
IBUPROPHEN	YES	NO	VALIUM	YES	NO

OTHER____

ARE YOU TAKING ANY OF THE FOLLOWING DRUGS OR MEDICINES?

ACETAMINOPHEN	YES	NO	CORTISONE	YES	NO
ANTIBIOTICS	YES	NO	HEART MEDICINE	YES	NO
ANTICOAGULATS	YES	NO	HIGH BLOOD PRESSURE	YES	NO
ANTI DEPRESSANTS	YES	NO	INSULIN OR SIMILAR DRUG	YES	NO
ASPIRIN	YES	NO	NITROGLYCERIN	YES	NO
BLOOD THINNERS	YES	NO	TRANQUILIZERS	YES	NO

If so, please list Cardiologist information:____

Do you have any disease or a condition not listed here?____

PLEASE LIST ALL MEDICATIONS THAT YOU ARE TAKING: _______________________________________

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CONSENT FOR DENTAL TREATMENT

I HEREBY CONSENT TO THE TREATMENT INDICATED ON MY EXAMINATION FORM, INCLUDING THE USE OF ANY ANESTHETICS, SEDATIVES, X-RAYS, OR DIAGNOSTIC PHOTOS AS MAY BE DEEMED NECESSARY BY DR. SHOEMAKER & HIS DENTAL TEAM.

____   _______________________________

Signature of Patient   Date