### **John Shoemaker, D.D.S., D.I.C.O.I. \*1609 N HWY 75, Suite 300\* Sherman, TX 75090\*(903) 893-7751**

Date:

Name: Date of Birth: SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex:

Address: City/State: Zip Code:

Home #: Cell #: Text: O Yes O No

Email: Facebook: 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:

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**

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?

Are you now under a care of pain management doctor? O Yes O No

Pain Management Information: Phone:

Cardiologist Information: Phone:

**PREFERRED PHARMACY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DO ANY OF THE FOLLOWING APPLY TO YOU?**

Have you ever had a hip or joint replacement? O YES O NO WHEN?

Do you have Congenital Heart Disease/Defect? O Yes O No

Are you required to take an antibiotic prior to dental treatment? 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 any major surgery, hospitalization or x-ray treatment? 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?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgery?\_\_\_\_\_\_\_\_Chemo?\_\_\_\_\_\_\_\_Radiation?\_\_\_\_\_\_\_\_

Do you smoke? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Use tobacco? \_\_\_\_\_\_\_\_\_\_ Drink alcohol? \_\_\_\_\_\_\_\_\_\_daily\_\_\_\_\_weekly\_\_\_\_

Recreational drug use? \_\_\_\_\_\_\_\_\_\_\_\_ Prescription Drug Abuse? \_\_\_\_\_\_\_\_\_\_\_ Recovery/Sobriety \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DO YOU WEAR ANY OF THE FOLLOWING?**

Contact Lenses O Yes O No Oxygen Daily O Yes O No C-Pap Machine O Yes O No

Pacemaker O Yes O No Nebulizer O Yes O No

## WOMEN

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

OB/GYN Dr \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DO YOU HAVE ANY OF THE FOLLOWING DISEASES OR PROBLEMS:**

ANEMIA YES NO HIGH BLOOD PRESSURE YES NO

ARTHRITIS RA or IR YES NO HIV OR AIDS YES NO

ASTHMA - SEASONAL/ACTIVE YES NO KIDNEY DIALYSIS/DISEASE YES NO

AUTO IMMUNE DISEASE YES NO LUPUS YES NO

DIABETES-TYPE \_\_\_\_ A1C \_\_\_\_ YES NO MULTIPLE SCLEROSIS YES NO

EPILEPSY/SEIZURES YES NO ORGAN TRANSPLANT YES NO

EMPHYSEMA/COPD YES NO OSTEOPOROSIS/PENIA YES NO

GLAUCOMA/BLIND/OTHER YES NO PAIN MANAGEMENT THERAPY YES NO

HEAD INJURY/TRAUMA YES NO STOMACH ULCERS /REFLUX YES NO

HEARING/HEARING AID YES NO STROKE YES NO

HEART DISEASE/ATTACK YES NO THYROID DISEASE YES NO

HEART STINT/BYPASS/SHUNT YES NO TUBERCULOSIS-CLEAR X-RAY­­ YES NO

HEPATITIS A, B, C YES NO VENEREAL DISEASE YES NO

HERPES SIMPLEX I OR II YES NO

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

ACETAMINOPHEN YES NO IODINE YES NO

ASPIRIN YES NO LATEX YES NO

CODEINE YES NO LOCAL ANESTHETIC YES NO

EPINEPHRINE YES NO PENICILLIN YES NO

ERYTHROMYCIN YES NO SEDATIVES YES NO

HALCION YES NO SULFA YES NO

IBUPROPHEN YES NO TETRACYCLINE YES NO

OTHER

## ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING TYPES OF MEDICATION?

ANTIBIOTICS YES NO CORTISONE YES NO

ANTICOAGULATS YES NO HEART MEDICINE/NITRO YES NO

ANTI DEPRESSANTS/ANXIETY YES NO HIGH BLOOD PRESSURE YES NO

ASPIRIN YES NO INSULIN OR SIMILAR DRUG YES NO

BISOPHOSPHONATES YES NO RX PAIN MEDS YES NO

BLOOD THINNERS YES NO TRANQUILIZERS YES NO

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

**PLEASE LIST ALL PRECRIPTION/OVER THE COUNTER/HERBAL MEDICATIONS THAT YOU ARE TAKING:**

## 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