C. Brian Herring, D.D.S.
3315 64th St, Lubbock, TX, 79413
(806)-792-6323

Patient Information 2015

Patient

Name:_____ Preferred:_____
First Last Middle Initial

DOB: _____ Gender: M F Marital Status: S M D W

Age: _____ SSN:_____

Address:_____

City:_____ State:_____ ZIP:_____

Phone: Home_____ Work 1_____

Cell_____ Work 2_____ Daytime Call: H C W1 W2

E-mail:_____

Employed By:_____ Student: Y N Where?_____

Spouse's Name:_____ Employed by:_____

Primary Dental Insurance

Insured party:_____ Relationship to insured party:_____

Insured party's employer:_____ Insurance Co: _____

ID #:_____

Medical History

Primary Physician:_____ Phone:_____

Please list any drug allergies:_____

Please list all medications you are currently taking (including over the counter): _____

_____

Please circle yes or no to the following:

Are you under any medical treatment now? Y N Why? _____

Have you ever had any major operations in the last three years? Y N _____

Are you or do you think you may be pregnant? Y N Trimester: _____

Do you use tobacco products? Y N _____

Anemia Y N
Arthritis Y N
Artificial Joint Y N
Aspirin Y N
Asthma Y N
Birth Control Y N
Blood Thinner Y N
Blood Transfusion Y N
Cancer Y N _____
Chemotherapy Y N
Coumadin Y N
Diabetic Y N

Emphysema Y N
Epilepsy or Seizures Y N
Glaucoma Y N
GI Problems Y N
Headaches Y N
Heart Murmur Y N
Heart Pacemaker Y N
Heart Problems Y N
Heart Attack Y N
Hepatitis Y N (A B C)
Herpes Y N
High Blood Pressure Y N
HIV Positive/AIDS Y N

Latex Allergy Y N
Liver Problems Y N
Mitral Valve Prolapse Y N
Panic Disorder/Nervous Y N
Plavix Y N
Prolonged Bleeding Y N
Rheumatic Fever Y N
Sleep Apnea/CPAP Y N
Stroke Y N
Strong Gag Reflex Y N
Tuberculosis Y N
Thyroid Problems Y N

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Dental History

Last visit to a dentist: _____
Date Reason Dr.

Last time x-rays were taken of my teeth: _____
Have you had any serious trouble associated with previous dental treatment? Y N
Explain: _____

Check the following applicable boxes and provide details when necessary:

- € Prolonged bleeding after tooth extractions
- € Excessive pain or swelling after oral surgery:_____
- € Undesirable reaction to local or general anesthetics:_____
- € Clenching or grinding your teeth
- € Sensitivity to cold/hot or sweets
- € Dissatisfied with the appearance of your teeth:_____
- € Gum bleeding
- € Bad taste in mouth
- € Packing food between teeth
- € Jaw clicking or popping
- € Have you ever received treatment for periodontal disease: _____
- € Has a dentist ever adjusted your bite: _____

What are your overall feelings towards your teeth and oral health? _____

_____

To the best of my knowledge, all of the above answers and information are true and correct. If there are any changes I will notify Dr. C. Brian Herring at my next appointment.

_____
Signature Date

_____
Signature Date

_____
Signature Date

_____
Signature Date

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