JOSHUA AUSTIN, DDS
family, cosmetic & implant dentistry

Thank you for the opportunity to evaluate your dental condition. In order to provide the best service for you, please complete the following information.

About You

Last Name:_____ First Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Home #:_____ Work #:_____ Mobile #:_____

email:_____ Gender:_____ SS#:_____

DOB:_____ Marital Status:_____ Employer:_____

Who may we thank for referring you?:_____

Responsible Party ❑ Same as above

Last Name:_____ First Name:_____

DOB:_____ SSN#:_____

Employer:_____ Work #:_____

Insurance Information

Insurance Company:_____ ID#:_____

Claims Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Group #:_____

Policy Holder:_____ DOB:_____ Relationship to patient:_____

Group Name/Employer:_____

Additional Insurance Information

Secondary Dental Plan:_____ Group#:_____

Policy Holder:_____ DOB:_____

Group Name/Employer:_____ SSN:_____

4553 N. Loop 1604 West Suite 1211 • San Antonio, TX 78249 • (210) 408-7999 • Fax (210) 592-8598 • www.JoshuaAustinDDS.com

Dental Health

What is your immediate concern? _____

_____

_____

Please answer YES or NO to the following:

Personal History

Are you fearful of dental treatment?	YES NO
Have you had an unfavorable dental experience?	YES NO
Have you ever had complications from past dental treatment?	YES NO
Have you ever had trouble getting numb or had reactions to local anesthetic?	YES NO
Did you ever have braces, orthodontic treatment or had your bite adjusted?	YES NO
Have you had any teeth removed?	YES NO

Gums & Bone

Do your gums bleed or are they painful when brushing or flossing?	YES NO
Have you ever been treated for gum disease or been told you have lost bone around your teeth?	YES NO
Have you ever noticed an unpleasant taste or odor in your mouth?	YES NO
Is there anyone with a history of periodontal disease in your family?	YES NO
Have you ever experienced gum recession?	YES NO
Have you ever had any teeth become loose on their own (without injury)?	YES NO
Have you experienced a burning sensation in your mouth?	YES NO

Tooth Structure

Have you had any cavities within the past three years?	YES NO
Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing food?	YES NO
Do you feel or notice any holes on the biting surface of your teeth?	YES NO
Are your teeth sensitive to hot, cold, biting, sweets or brushing?	YES NO
Do you have grooves or notches on your teeth near the gum line?	YES NO
Have you ever broken teeth, chipped teeth or had a toothache or cracked filling?	YES NO
Do you frequently get food caught between any teeth?	YES NO

Bite & Jaw Joint

Do you have any problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	YES NO
Do you feel like your lower jaw is being pushed back when you bite your teeth together?	YES NO
Do you avoid or have difficulty chewing gum, carrots, nuts or other hard foods?	YES NO
Have your teeth changed in the last 5 years, become shorter, thinner or worn?	YES NO
Are your teeth crowding or developing spaces?	YES NO
Do you have more than one bite and have to squeeze to make your teeth fit together?	YES NO
Do you chew ice, bite your nails, use your teeth to hold objects or have any other oral habits?	YES NO
Do you clench your teeth in the day time or make them sore?	YES NO
Do you have any problems with sleep or wake up with an awareness of your teeth?	YES NO
Do you wear or have you ever worn a bite appliance?	YES NO

Smile Characteristics

Is there anything about the appearance of your teeth that you would like to change?	YES NO
Have you ever whitened (bleached) your teeth?	YES NO
Have you ever felt uncomfortable or self-conscious about the appearance of your teeth?	YES NO
Have you ever been disappointed with the appearance of previous dental work?	YES NO

Please use the space below to indicate any other problems, concerns or questions. We will make every effort to listen attentively to your concerns so that we can present you with the best possible treatment options.

_____

_____

_____

Medical Health

Name of Physician:_____

Have you been under the care of a physician in the past 2 years? No__ Yes__ if yes, why?_____

_____

Have you been treated in a hospital in the past 2 years? No__ Yes__ if yes, why?_____

_____

Are you now or have you taken any prescription drugs during the past year? If so, please list.

_____

Do you use tobacco products?_____

Have you ever been told that you need antibiotics prior to dental treatment?_____

Are you allergic or sensitive to any medication? _____

Indicate which of the following you have had, or have at present. Circle yes or no on each item.

Heart disease	YES	NO	Angina	YES	NO	Jaundice	YES	NO	HIV	YES	NO
Arthritis	YES	NO	Kidney Disease	YES	NO	Diabetes	YES	NO	Artificial Heart Valves	YES	NO
Liver Disease	YES	NO	Heart Murmur	YES	NO	Artificial Joints	YES	NO	Organ Transplant	YES	NO
Hepatitis	YES	NO	Asthma	YES	NO	Pacemaker	YES	NO	Pregnant	YES	NO
Cancer	YES	NO	Polio	YES	NO	Prolonged Bleeding	YES	NO	Chemotherapy	YES	NO
Cough	YES	NO	Rheumatic Fever	YES	NO	Congenital Heart Issue	YES	NO	Psychiatric Treatment	YES	NO
Stroke	YES	NO	Drug Dependence	YES	NO	Radiation Therapy	YES	NO	Tuberculosis	YES	NO
Epilepsy	YES	NO	Sickle Cell Anemia	YES	NO	Abnormal Blood Pressure	YES	NO	Fainting	YES	NO
Thyroid Disease	YES	NO	Allergies	YES	NO	Glaucoma	YES	NO	Ulcers/Acid Reflux	YES	NO
Anemia	YES	NO	Herpes	YES	NO	Venereal Disease	YES	NO	Sleep Apnea	YES	NO

Do you have any diseases, conditions, or problems not previously listed?_____

_____

Have you recently used illegal drugs? YES NO. If yes, please list:_____

Sleep Apnea

The following survey has been provided to aid you in diagnosing and curing issues which might be related to snoring, upper air resistance and sleep apnea.

Please circle your condition during the following activities.

0= Would never doze 1= Slight chance of dozing 2= Moderate chance of dozing 3= High chance of dozing

1. Sitting and reading	0 | 1 | 2 | 3
2. Watching television	0 | 1 | 2 | 3
3. Sitting inactively in a public place	0 | 1 | 2 | 3
4. As a passenger in a car for an hour without break.	0 | 1 | 2 | 3
5. Lying down to rest in the afternoon.	0 | 1 | 2 | 3
6. Sitting and talking to someone.	0 | 1 | 2 | 3
7. Sitting quietly after lunch without alcohol.	0 | 1 | 2 | 3
8. Driving a car stopped in traffic or at a stop light.	0 | 1 | 2 | 3
9. Have you ever been told you snore?	YES NO
10. Do you wake up feeling fatigued?	YES NO
11. Do you have morning headaches?	YES NO
12. Have you been diagnosed with chronic fatigue syndrome, fibromyalgia, or TMJ	YES NO

13. Any additional comments that may be helpful? _____

_____

I hereby authorize Dr. Joshua Austin to perform procedures, including but not limited to: giving local anesthetic and medications; making radiographs and photographs to be used in professional presentations; performing head & neck examination; restoring teeth; any necessary restorative therapy. I certify that I have read and fully understand the above and consent to treatment. I authorize the release of any information necessary to process my insurance claim and also hereby authorize payment of insurance benefits to Joshua Austin, DDS. A copy of this signature is valid as the original. Your name and signature indicate that you have received a copy of our Notice of Privacy Practices on the date indicated.

Signature:_____

Date:_____

Emergency Name & Contact #:_____

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HIPAA Patient Acknowledgment of Receipt of Privacy Practices

"You May Refuse to Sign"

Our Privacy Practices

Your Patient Rights

- You may request a copy of this notice and we will provide one to you
- You may request in writing that we communicate your health information by alternative means such as email or fax or to alternative locations
- You have a right to copies of your own health information. We will let you know if any copying fees will be assessed
- You may request that we amend your health information

Uses and Disclosures of Your Private Health Information

- To yourself
- To family and/or friends that you authorize for the purposes of helping you with your healthcare or for payment of services
- To obtain payment
- To other healthcare providers involved in your care
- To notify your family or representative about your care and health status as needed
- To cooperate with law enforcement for reasons not limited to but including abuse, neglect, domestic violence, or crime victim
- To military authorities if you are personnel of the Armed Forces and the information is needed for lawful intelligence, counterintelligence, or other national security purpose
- To correctional institutions if you are an inmate
- To facilitate our own quality assessments and improvements, reviewing competence of healthcare professionals, evaluation of practical performance, training programs, accreditation, certifications, licensing, or credentialing activities
- To provide you with appointment reminders such as voicemail or mailers

I, _____, have received a copy of the Notice of Privacy Practices. I understand that the purpose of this form is to document that the office of Joshua Austin, DDS, has made an effort in helping me be aware of the required privacy practices under the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

_____

Print Name

_____ _____

Signature **Date**