*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 #:_____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
HEARNIG/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