H. Ray Hix, D.D.S.

Family Dentistry

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Patient Information

First Name: _____ Last Name: _____ Middle Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____ E-Mail: _____
Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed
Birth Date: _____ Age: _____ Social Security # _____ Physician: _____
Occupation: _____ Employer Name: _____
Employer's address: _____ City: _____ State: _____ Zip: _____
Referred by: ☐ Passing By; ☐ Another Patient; ☐ Relative; ☐ Friend; ☐ Internet; ☐ Yellow Pages; ☐ Other _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment
First Name: _____ Last Name: _____ Middle Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Birth Date: _____ Social Security # _____ E-Mail: _____
Occupation: _____ Employer Name: _____
Employer's address: _____ City: _____ State: _____ Zip: _____

Insurance Information

Subscriber's Name: _____ Relationship to Patient: _____
Insurance Co: _____ Policy #: _____
Is there any additional dental insurance? ☐ Yes ☐ No
Subscriber's Name: _____ Relationship to Patient: _____
Insurance Co: _____ Policy #: _____

Health History

	Yes	No		Yes	No
Is your general health good?	☐	☐	Have you been hospitalized or had major operation?	☐	☐
Are you under a physician care now?	☐	☐	Are you taking any medication, pills, or drug?	☐	☐
Have you ever had trouble with bleeding after surgery?	☐	☐	Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
Have you ever had a serious head or neck injury?	☐	☐			
Do you take, or have you taken, Fen-Phen / Redux?	☐	☐			
Have you ever had heart trouble, rheumatic fever, diabetes, infectious hepatitis, tuberculosis or AIDS?	☐	☐	Have you ever had an unusual reaction to any drug or local anesthetic?	☐	☐

Is there any other information about your health which should be known? ☐ Yes ☐ No If Yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____