

Welcome

Thank you for choosing our practice. Please fill out this form as completely as you can. If you have any questions we'll be glad to help. (Please print)

CITY CREEK DENTAL • DEREK WINEGAR, DDS • 803 SOUTH 37TH STREET TEMPLE, TX 76504 • (254) 778-1990

PATIENT INFORMATION

Name _____ [] Dr. [] Mr. [] Mrs. [] Ms. [] Rev. [] Other: _____
First MI Last
Address _____ Occupation: _____ [] Male [] Female
City _____ State _____ Zip _____ Hm# (____) _____
Employer _____ Wk# (____) _____ Ext _____
Are you: [] Minor [] Married [] Single [] Divorced [] Widowed [] Separated Cell # (____) _____
DOB: ____/____/____ SSN# _____ E-mail _____@_____
Spouse's Name _____
First MI Last (if different)
Spouse occupation _____ Work phone _____ Ext _____
Is patient a full time student? [] No [] Yes: Name of school: _____

RESPONSIBLE PARTY (if different than patient)

Name _____
First MI Last
Address _____
City _____ State _____ Zip _____
Hm# (____) _____
Wk# (____) _____
DOB: ____/____/____
SSN# _____

About Dr. Winegar:

Doctor of Dental Surgery, Medical College of Virginia

Member:

Academy of General Dentistry American Academy of Cosmetic Dentistry

Fellow - International Congress of Oral Implantologists

Alumni:

Spears Center for Advanced Dental Education

UT Health Science Center SA Preceptorship in Implantology

Relationship: _____

INSURANCE INFORMATION

MEDICAL INSURANCE:

Subscriber's Name _____ Relationship to patient: _____
DOB: ____/____/____ Subscriber's SSN# _____
Insurance Company _____ Policy # _____ Group # _____

DENTAL INSURANCE:

Insured Name _____ Relationship to patient: _____
Address _____ City _____ State _____ Zip _____
DOB: ____/____/____ SSN# _____ Employer: _____
Insurance Company _____ Group # _____ Eff. Date: ____/____/____
DO YOU HAVE ADDITIONAL DENTAL INSURANCE? [] Yes [] No If yes, please complete the following:
Insured Name _____ Relationship to patient: _____
Address _____ City _____ State _____ Zip _____
DOB: ____/____/____ SSN# _____ Employer: _____
Insurance Company _____ Group # _____ Eff. Date: ____/____/____

YOUR PREFERENCES

Do you prefer appointment reminders by: [] Email [] Phone [] Text
Do you prefer to receive calls from our office at: [] Home [] Work [] Cell
Whom may we thank for referring you? _____ How do you wish to be addressed by our staff?



Our practice is one of the most advanced CAD/CAM practices in the US. We use 3-D CEREC technology to produce ceramic restorations in a single visit.

"Our practice is dedicated to helping you have good oral health for a lifetime."
Derek Winegar, DDS

CONFIDENTIAL

CEREC 3D

Our practice uses CEREC 3D technology (left) to make ceramic crowns, onlays, and veneers in a single appointment.

MEDICAL HISTORY and CONSENT

Although dental personnel treat the area in and around your mouth, your mouth is a part of your entire body. Health conditions or problems that you may have or had, or medications that you may be taking, could have an important interrelationship with the treatment you will receive. Thank you for answering the following questions.

Allergies

Acrylics	Y	N
Anaphalaxis	Y	N
Latex	Y	N
Local Anesthetics	Y	N
Penicillin	Y	N
Metal	Y	N
Sulpha	Y	N
Other	Y	N

List other known allergies:

Cardiovascular

Artificial Heart Valve	Y	N
Coronary Artery Disease	Y	N
Chest Pain or Angina	Y	N
Congestive Heart Failure	Y	N
Heart Attack	Y	N
Heart Murmur	Y	N
High Blood Pressure	Y	N
High Cholesterol	Y	N
Irregular Heart Beat	Y	N
Low Blood Pressure	Y	N
Mitral Valve Prolapse	Y	N
Pacemaker	Y	N
Tachycardia	Y	N

Endocrine

Diabetes	Y	N
Gout	Y	N
Hormonal Change	Y	N
Thyroid problems	Y	N

Eyes, Ears, Nose and Throat

Change in Hearing	Y	N
Change in Vision	Y	N
Dysphagia	Y	N
Ear Pain	Y	N
Glaucoma	Y	N
Hay Fever	Y	N
Nasal Obstruction	Y	N
Nose Bleeding	Y	N
Sinus Problems	Y	N
Tonsillectomy	Y	N
Tinnitus	Y	N

Gastrointestinal

Acid Reflux	Y	N
GERD	Y	N
Soft or Special Diet	Y	N
Ulcers	Y	N

Genitourinary

Frequent Urination	Y	N
Kidney disease	Y	N
Nocturia	Y	N

General

Current weight: _____ lbs	
Height: _____ ft _____ in	
Cancer	Y N
Fatigue/Tired	Y N
General Weakness	Y N
Headaches	Y N
HIV/AIDS	Y N
Knee/hip replacement	Y N
Liver problems	Y N
Recent Trauma or Injury	Y N
Rheumatic Fever	Y N
Radiation Treatment	Y N
Weight Change	Y N

Hematological

Bleeding problems	Y	N
Hepatitis	Y	N

Oral

Bleeding gums	Y	N
Dry mouth	Y	N
Jaw problems (TMJ)?	Y	N
Clicking?	Y	N
Pain?	Y	N
Difficulty swallowing?	Y	N
Difficulty chewing?	Y	N
Orthodontics/Invisalign	Y	N
Periodontal Disease	Y	N
Teeth clenching	Y	N
Teeth grinding	Y	N
Tooth pain	Y	N
Wisdom teeth extraction	Y	N
Do you wear removable teeth?	Y	N
Do you take or need antibiotics before dental procedures?	Y	N

Musculoskeletal

Back Pain	Y	N
Fibromyalgia	Y	N
Joint Pain	Y	N

Neurological

Alzheimer's Disease	Y	N
Dizziness	Y	N
Fainting	Y	N
Memory Loss	Y	N
Multiple Sclerosis (MS)	Y	N
Muscle Weakness	Y	N
Seizures	Y	N
Stroke	Y	N
Tingling/Numbness	Y	N
Trigeminal Neuralgia	Y	N
Tremor	Y	N

Psychiatric

ADD/ADHD	Y	N
Anxiety	Y	N
Chemical Dependency	Y	N
Depression	Y	N
Eating disorders	Y	N
Excessive Stress	Y	N
Memory problems	Y	N

Respiratory

Asthma	Y	N
Bronchitis	Y	N
Breathing problems	Y	N
Chest Pressure	Y	N
Congestion	Y	N
Dyspnea (shortness of breath)	Y	N
Emphysema	Y	N
Orthopnea	Y	N
Pneumonia	Y	N
Pulmonary Embolism	Y	N
Tuberculosis	Y	N

Sleep

Daytime Sleepiness	Y	N
Morning headaches	Y	N
Obstructive Sleep Apnea	Y	N
Do you use a CPAP?	Y	N
How often? _____		
Has anyone told you that you snore?	Y	N

Social History

Do you smoke? N Y ___ packs a day	
Do you use smokeless tobacco? Y N	
Do you consume alcoholic beverages? _____ Drinks per day/week/month	
Do you use recreational drugs? Y N	

CONFIDENTIAL