Welcome

Brent Huckabay, D.D.S.
2000 W Cuthbert
Midland, TX 79701

❶ ABOUT YOU

Today's Date: ______/______/______

Patient Name:________________________________
What You Prefer To Be Called:______________
❏ Male ❏ Female Birth Date: _____/_____/_____
SS# _____-_____-_____
Status: ❏ Minor ❏ Married ❏ Single
❏ Divorced ❏ Widowed
Spouse's Name: ______________________________
Mailing Address: ____________________________

________________ ______________ ______________
City State Zip Code
Home Phone # (______) ______ - __________
Work Phone# (______) ______ - __________
Cell Phone # (_____) ______ - __________
E-mail:______________________________________
Referred By: _________________________________
Employer:____________________________________
Employers Address: ___________________________

________________ ______________ ____________
City State Zip Code

❷ INSURANCE INFO

PRIMARY DENTAL INSURANCE
Company Name: ___________________________
Address: _________________________________

___________ ____________ __________
City State Zip
Phone: (_____) ______ - __________
Insured SS # ______ - ______ - ______
Group # (Plan, Local, or Policy#) ____________
Insured's Name: ___________________________
Relation: _________ D.O.B. ____/____/____
Insured's Employer: ________________________

SECONDARY DENTAL INSURANCE
Company Name:___________________________
Address: _________________________________

___________ ___________ ___________
City State Zip
Phone: (____) _____ - __________
Insured's SS # ______-______-______
Group # (Plan, Local or Policy #) ___________
Insured's Name: ___________________________
Relation: __________ D.O.B. ____/____/____
Insured's Employer: ________________________

❸ ACCOUNT INFO

PERSON ULTIMATELY RESPONSIBLE FOR ACCOUNT
Name: ______________________________________
Relation: ____________________________________
Billing Address: ______________________________

_____________ _____________ _____________
City State Zip Code
SS # _______ - _______ - _______
Driver License# _____________ State: ___________
Home Phone # (_____) ______ - __________
Work Phone # (_____) ______ - __________
Cell Phone # (_____) ______ - ___________

____ I hereby authorize assignment of my insurance
initials rights and benefits directly to the provider for service rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

❹ IN CASE OF AN EMERGENCY

Who should we contact? _______________________
Relation: ___________________
Home Phone# (____) _____ - ________
Work Phone # (____) _____ - ________
Cell Phone # (_____) _____ - ________

❺ DENTAL INFORMATION

Are you in pain? ❑ NO ❑ YES How Long? _______________

Please indicate any of the following problems:

❑ Discomfort, clicking or popping in jaw ❑ Teeth Grinding ❑ Bad Breath

❑ Red, swollen or bleeding gums ❑ Broken/Chipped tooth ❑ Other _______

❑ Lost/Broken Filling(s)

Are you happy with your smile? ❑ Yes ❑ No

Do you require pre-medications? ❑ Yes ❑ No ❑ Don't Know

Last Dental Exam: ______/______/______ Last Dental X-Rays: ______/______/______

❻ MEDICAL HISTORY

Are you taking any blood thinners? ❑ Aspirin ❑ Pre Medications ❑ Other (s) please list any other medications you are taking: ____

____

Do you have or have had any of the following diseases, medical conditions or procedures?

Y N Heart attack / Stroke	Y N Heart Surgery / Pacemaker	Y N Heart Murmur	Y N Rheumatic Fever
Y N Mitral Valve Prolapse	Y N High/Low Blood Pressure	Y N Heart Disease	Y N Congenitial Heart Defect
Y N Chest Pains	Y N Respiratory Problems	Y N Scarlet Fever	Y N Sinus Problems
Y N Alcohol/Drug Abuse	Y N Hepatitis	Y N Bleeding Problems	Y N Tuberculosis TB
Y N HIV+/AIDS/ARC	Y N Jaw Problems TMJ/TMD	y N Artificial Valves	Y N Seizures/Epilepsy
Y N Cancer/Tumors	Y N Artificial Bones/Joints	Y N Diabetes/Hypoglycemia	

Please list any other medical condition(s) you have or ever had:______________________________

Are you allergic to any of the following: ❑ Latex ❑ Penicillin ❑ Amoxicillin ❑ Tetracycline ❑ Dental Anesthetics ❑ Aspirin ❑ Others: ____________________________________

FOR WOMEN ONLY: Are you taking Birth Control pills? ❑ Yes ❑ No Are you pregnant: ❑ YES ❑ NO

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. Prior to receiving dental treatment, if the account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expense incurred in collecting your account.
- I authorize the staff to perform any necessary service (s) needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature______________________________________ Date _____/_____/_____

❑ Adult Patient ❑ Parent or Guardian ❑ Spouse