Welcome

We have two state-of-the-art facilities to meet all your dental needs!
Se Habla Espanol *Early and Evening Appointments Available

Stephens & Gatewood Dentistry

6315 Cypresswood Spring,TX 77379 **6922 West Rayford Suite 100 Spring, TX 77389**

Patient's Name _____ **[ ] Dr. [ ] Mr. [ ] Mrs. [ ] Ms. [ ]** Today's Date _____

Address _____ Occupation _____ [ ] Male [ ] Female
City _____ State _____ Zip _____ Home # _____

Employer _____ Work # _____ Cell # _____
DOB ___/___/___ SSN# _____ E-mail _____@_____

Spouse's Name _____ Cell #_____ Work # _____

HOW DID YOU HEAR ABOUT OUR OFFICE? [ ] Marketing Mailer [ ]Newsletter [ ] Yelp

[ ] Google [ ] Other Search Engine (which one)_____ [ ] Woodlands Online [ ] New Home Letter

[ ] Print Ads/Magazine or Referred by_____

RESPONSIBLE PARTY: (If different than patient)

Name _____ Relationship_____

Address _____

City _____ State _____ Zip _____

Home # _____

Work #_____

DOB _____/_____/_____

SSN# _____

WE ARE ALWAYS WELCOMING NEW PATIENTS!
Our most valued compliment are referrals!

Some of our services may be covered by your medical insurance. If so, medical coverage will reduce your out-of-pocket expense and preserve your dental benefits for procedures not covered by your medical insurance.

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 _____ Subscriber ID#_____Group # _____

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 _____ Subscriber ID#_____Group # _____

Person to contact in case of an emergency_____ Telephone #_____

Specializing in : *Cosmetic Dentistry*
Two Hour Crowns
Root Canal Therapy
Sedation Dentistry
Dental Implants
Oral Surgery
Sleep Apnea Therapy
Orthodontics

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"Our entire team of professionals are dedicated to exceeding your expectations in customer service as well as providing you with life changing dentistry!"
Stephens Gatewood & Associates

MEDICAL HISTORY and CONSENT

Although dental professionals 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
Codeine	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
Bacterial Endocarditis	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/Vision	Y	N
Hearing Aids	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
Pregnant or Nursing	Y	N

Hematological

Bleeding problems	Y	N
Hepatitis	Y	N
If yes, circle type	A B or C	

Oral

Date of last dental visit

_____

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

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

Have you been told you snore? Y N

Daytime Sleepiness	Y	N
Excessive Tiredness	Y	N
History of Hypertension	Y	N
History of Insomnia	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

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MEDICAL HISTORY and CONSENT

List any medications you are taking:

	Medication	Dosage/Freq.	Prescriber	Reason
1.				
2.				
3.				
4.				
5.				
6.				

List any surgeries or hospitalizations you have had:

Date(year)	Surgery	Surgeon	Reason

List and detail any medical condition or history not listed above:

_____

_____

_____

_____

Primary Physician's Name: _____ Physician's phone #: _____

Are you under the care of other physicians? If so, please list:

Physician Phone # Reason

_____

_____

_____

GENERAL CONSENT TO DIAGNOSE AND TREAT: The undersigned hereby authorizes Stephens Gatewood & Associates to take radiographs, study models, photographs, or any other diagnostic tools deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize Stephens Gatewood & Associates to perform any and all forms of treatment, medication, and therapy that may be deemed necessary by the doctors. I understand that the use of local anesthetics agents embodies certain risk and consent to their use as deemed appropriate. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/ the patient's health. It is my responsibility to inform the dental office of any change in medical health or status.

FINANCIAL CONSENT: I understand the responsibility for payment of services provided for myself and my dependent(s) is mine. As a courtesy, we will be happy to assist in filing insurance. The office will collect your estimated portion on the day service is rendered and wait 30 days to obtain the balance from my insurance. I understand that I am responsible for any portion of fees not covered by my dental or medical insurance after 30 days. Stephens Gatewood & Associates and staff will provide dental care based on the patient's needs and not based on insurance coverage. I authorize Stephens Gatewood & Associates and their staff to verify insurance coverage, submit claims, and provide my insurance company with information required for processing claims. I also give permission to assign benefits directly to Stephens Gatewood & Associates and for this office to handle any necessary claim appeals on my behalf.

Consent (adult):

Name of Patient _____ _____ **Date** _____

Signature of Patient

Consent (for a minor child):

Name of Parent/Guardian _____ _____ **Date** _____

Signature of Parent/Guardian

I allow release of pertinent medical records to my insurance company (if applicable) and my other medical providers.

_____ **Date** _____

Signature of Patient/Guardian

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SLEEP APNEA/SNORING (for patients 18 years of age or older)

Patient Name:_____ Date of Birth:_____

Do you know what sleep apnea means?	[ ] YES	[ ] NO
Have you ever been diagnosed with sleep apnea?	[ ] YES	[ ] NO
Do you now or have you ever used a CPAP machine?	[ ] YES	[ ] NO

SLEEP OBSERVATIONS:

Do you know you snore or have you ever been told you do?	[ ] YES	[ ] NO
Do you have difficulty breathing while lying on your back?	[ ] YES	[ ] NO
Do you ever wake up gasping for air?	[ ] YES	[ ] NO
Do you often feel tired or fatigued after a good nights sleep?	[ ] YES	[ ] NO
Has anyone ever noticed that you stop breathing during sleep?	[ ] YES	[ ] NO

EPWORTH SLEEP SCALE:

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Use the following scale to choose the most appropriate number for each situation. Please circle the numbers below to answer.

	Would Never doze	*Slight chance of dozing*	*Moderate chance of dozing*	*High chance of dozing*
*Sitting and reading	0	1	2	3
*Watching TV	0	1	2	3
*Sitting inactive in a public place	0	1	2	3
*As a passenger in a car for an hour without a break	0	1	2	3
*Lying down to rest in the afternoon	0	1	2	3
*Sitting and talking to someone	0	1	2	3
*Sitting quietly after lunch without alcohol	0	1	2	3
*In a car while stopped for a few minutes in traffic	0	1	2	3

TOTAL OF YOUR SCORE: _____