DR. DEREK WINEGAR
DR. CHANTEL KELLER
803 S. 37ST TEMPLE, TX 76504
254-778-1990

Welcome to City Creek Dental! We know you have many choices for dentists in our area. We are honored that you have selected our office. To help us meet all your healthcare goals, please fill out this form completely. If there is anything on this form which is unclear, feel free to ask us about it. We will be happy to assist you.

PATIENT INFORMATION

Prefix: _____ First Name: _____ Last Name: _____Suffix: _____

I prefer to be addressed as: _____

Please check if you are: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed

Birthdate: _____ Social Security #: _____ Cell #: _____

Email address: _____ Home #: _____

Mailing address: _____ Work #:_____

City: _____ State: _____ Zip: _____

How can we contact you? ☐Home ☐Cell ☐Work ☐E-mail **Can we leave a detailed message?** ☐Yes ☐No

Employer: _____

Emergency Contact: _____ Relationship to patient:_____

Phone #: _____

Whom may we thank for referring you?

☐Internet search ☐Online directory ☐Website

☐Friend/Family/Another patient: _____

☐Other: _____

Please tell us what's important to you in finding a dentist:

_____

_____

_____

☐**Check here if responsible party is self/patient**

Responsible party First Name: _____ Last Name: _____

Relationship to patient: ☐Spouse ☐Parent ☐Other: _____

Birthdate: _____ SS#: _____

Address (If not same as above): _____

City: _____State: _____Zip: _____

Insurance Company: _____ Employer: _____

Subscriber Name: _____ Birthdate: _____

ID or SS#: _____ Group #: _____

Insurance Phone #: _____

FINANCIAL CONSENT: I understand that responsibility for payment of services provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered. I understand that I am responsible for any portion of fees for services rendered not covered by my dental or medical insurance (if any). I further consent to and agree to pay a 1 1/2% finance charge (18% annually) that will be applied to any balance over 30 days. I acknowledge that I am responsible for all fees necessary to collect my account. I authorize Derek M. Winegar, DDS or Chantel Keller, DDS and his staff to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits, and to handle any necessary claim appeal(s).

Signature:_____ Date:_____

Notice of Privacy Practices (below)

Patient privacy is important to our practice. We are required by law to maintain the privacy of Protected Health Information ("PHI") and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. By signing below you are acknowledging receiving notice of our practices' policies and your rights regarding PHI. I allow release of pertinent medical records to my insurance company (if applicable) and my other medical providers.

Signature:_____ Date:_____

First Name:_____ Last Name:_____ Birthdate:_____

Patient's preferred pharmacy: _____ Pharmacy phone: _____

Physician:_____ Physician's phone: _____

1. List of Medications you are taking: (If you have a list we can copy, please give to front desk)

Medication:	Dosage:	Reason:	Medication:	Dosage:	Reason:

2. List of Surgeries, Hospitalizations or Medical Procedures:
(If you have a list we can copy, please give to front desk)

Care Received:	Date:	Doctor:

4. List any medical conditions or history not listed above:

_____

_____

_____

6. Are you currently on Medicinal Marijuana? ☐YES ☐NO

7. Are you currently using Tobacco products? ☐YES ☐NO

8. **Are you currently taking or have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?** ☐YES ☐NO

3. **Are you allergic to, or have you had any reaction to, the following:**

Aspirin	☐YES	☐NO
Codeine	☐YES	☐NO
Local anesthetics	☐YES	☐NO
Penicillin	☐YES	☐NO
Sulfa drugs	☐YES	☐NO
Sedatives	☐YES	☐NO
Iodine	☐YES	☐NO
Any metals	☐YES	☐NO
Latex rubber	☐YES	☐NO
Acrylic	☐YES	☐NO

Other antibiotics :_____

Other: _____

WOMEN ONLY: Are you pregnant?	☐YES	☐NO
Are you trying to get pregnant?	☐YES	☐NO
Are you taking oral contraceptives?	☐YES	☐NO
Are you nursing?	☐YES	☐NO

9. Do you have or have you had any of the following:

Aids/hiv positive	☐YES ☐NO	Excessive bleeding	☐YES ☐NO	Mitral valve prolapse	☐YES ☐NO
Alzheimer's disease	☐YES ☐NO	Excessive thirst	☐YES ☐NO	Osteoporosis	☐YES ☐NO
Anaphylaxis	☐YES ☐NO	Fainting spells/dizziness	☐YES ☐NO	Pain in jaw joints	☐YES ☐NO
Anemia	☐YES ☐NO	Frequent cough	☐YES ☐NO	Parathyroid disease	☐YES ☐NO
Angina	☐YES ☐NO	Frequent diarrhea	☐YES ☐NO	Psychiatric care	☐YES ☐NO
Arthritis/gout	☐YES ☐NO	Frequent headaches	☐YES ☐NO	Radiation treatments	☐YES ☐NO
Artificial heart valve	☐YES ☐NO	Glaucoma hay fever	☐YES ☐NO	Recent weight loss/gain	☐YES ☐NO
Artificial joint	☐YES ☐NO	Heart attack/failure	☐YES ☐NO	Renal dialysis	☐YES ☐NO
Asthma	☐YES ☐NO	Heart murmur	☐YES ☐NO	Rheumatic fever	☐YES ☐NO
Blood disease	☐YES ☐NO	Heart pacemaker	☐YES ☐NO	Rheumatism	☐YES ☐NO
Blood transfusion	☐YES ☐NO	Heart trouble/disease	☐YES ☐NO	Scarlet fever	☐YES ☐NO
Breathing problem	☐YES ☐NO	Hemophilia	☐YES ☐NO	Shingles	☐YES ☐NO
Bruise easily	☐YES ☐NO	Hepatitis A	☐YES ☐NO	Sickle cell disease	☐YES ☐NO
Cancer _____	☐YES ☐NO	Hepatitis B or C	☐YES ☐NO	Sinus trouble	☐YES ☐NO
Chemotherapy	☐YES ☐NO	Herpes	☐YES ☐NO	Spina bifida	☐YES ☐NO
Chest pains	☐YES ☐NO	High blood pressure	☐YES ☐NO	Stomach/intestine disease	☐YES ☐NO
Cold sores/fever blisters	☐YES ☐NO	High cholesterol	☐YES ☐NO	Stroke	☐YES ☐NO
Congenital heart disease	☐YES ☐NO	Hives or rash	☐YES ☐NO	Swelling of limbs	☐YES ☐NO
Convulsions	☐YES ☐NO	Hypoglycemia	☐YES ☐NO	Thyroid disease	☐YES ☐NO
Cortisone medicine	☐YES ☐NO	Irregular heartbeat	☐YES ☐NO	Tonsilitis	☐YES ☐NO
Diabetes	☐YES ☐NO	Kidney problems	☐YES ☐NO	Tuberculosis	☐YES ☐NO
Drug addiction	☐YES ☐NO	Leukemia	☐YES ☐NO	Tumors or growths	☐YES ☐NO
Easily winded	☐YES ☐NO	Liver disease	☐YES ☐NO	Ulcers	☐YES ☐NO
Emphysema	☐YES ☐NO	Low blood pressure	☐YES ☐NO	Other _____	
Epilepsy or seizures	☐YES ☐NO	Lung disease	☐YES ☐NO		

GENERAL CONSENT TO DIAGNOSE AND TREAT: The undersigned hereby authorizes, Derek M. Winegar, DDS or Chantel Keller, DDS to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize Derek M. Winegar, DDS to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that Derek M. Winegar, DDS or Chantel Keller, DDS choose and employ such assistance as deemed necessary. I understand that the use of local anesthetics agents embodies certain risk and consent to their use as deemed appropriate by Derek M. Winegar, DDS or Chantel Keller, DDS. 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.

Signature:_____ Date:_____