Patient Information Form

Briarfield DENTAL CARE

Patient Information

Name _____ _____ _____
First *MI* *Last*

Date of Birth ____ / ____ / ____ Social Security # ____ - ____ - ____

Address _____

City _____ State _____ Zip _____

Email _____ *Would you like to be contacted by email?* ☐ *Yes* ☐ *No*

Home Phone _____ Cell Phone _____

Gender _____ Patient is: ☐ *Minor* ☐ *Student* ☐ *Single* ☐ *Married*
☐ *Divorced* ☐ *Seperated* ☐ *Widowed*

If Student...

Name of School / College _____

If Minor...

Name of Parents / Guardian _____

Parent / Guardian's Employer _____

Occupation _____

Business Address _____

Whom may we thank for referring you to our office?

_____

Responsible Party

Name _____ _____ _____
First *MI* *Last*

Relationship to Patient _____

Date of Birth ____ / ____ / ____ Social Security # ____ - ____ - ____

Address (if different) _____

City _____ State _____ Zip _____

Email _____ *Would you like to be contacted by email?* ☐ *Yes* ☐ *No*

Employer _____

Work Phone _____ Cell Phone _____

Is this person currently a patient in our office? ☐ *Yes* ☐ *No*

Spouse Information

Name _____ _____ _____
First *MI* *Last*

Date of Birth ____ / ____ / ____ Social Security # ____ - ____ - ____

Employer _____

Occupation _____

Work Phone _____ Cell Phone _____

Business Address _____

Relative

Nearest relative not living with you

Name _____ _____ _____
First *MI* *Last*

Home Phone _____ Cell Phone _____

Address _____

City _____ State _____ Zip _____

Patient Information Form cont.

Insurance Information

Primary Dental Insurance _____

Name of Insured _____

Secondary Dental Insurance _____

Name of Insured _____

Patient Medical Information

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

General Health ☐ *Excellent* ☐ *Good* ☐ *Fair* ☐ *Poor*

Name of Physician _____

Address _____

Phone Number _____ Date of Last Exam ____ / ____ / ____

Are you under a physician's care now? ☐ *Yes* ☐ *No*

If yes, please explain _____

Have you ever been hospitalized or had a major operation? ☐ *Yes* ☐ *No*

If yes, please explain _____

Have you ever had a serious head or neck injury? ☐ *Yes* ☐ *No*

If yes, please explain _____

Are you taking any medications, pills, or drugs? ☐ *Yes* ☐ *No*

If yes, please explain _____

Do you take, or have you taken Phen-Fen or Redux? ☐ *Yes* ☐ *No*

Have you ever taken Fosamax, Boniva, Actenol or any other medication containing bisphosphonates? ☐ *Yes* ☐ *No*

If yes, please explain _____

Are you on a special diet? ☐ *Yes* ☐ *No*

Do you use tobacco? ☐ *Yes* ☐ *No*

Do you use controlled substances? ☐ *Yes* ☐ *No*

Are you allergic to any of the following?

☐ *Aspirin* ☐ *Penicillin* ☐ *Codeine* ☐ *Sulfa Drugs* ☐ *Acrylic* ☐ *Sedatives* ☐ *Local Anesthetics*

☐ *Metal* ☐ *Latex* ☐ *Adhesives* ☐ *Food Allergies* ☐ *Other*

If yes, please explain _____

Women: Are You?

Pregnant / Trying to get pregnant? ☐ *Yes* ☐ *No*

Nursing? ☐ *Yes* ☐ *No*

Taking Oral Contraceptives? ☐ *Yes* ☐ *No*

Do you have, or have you had, any of the following?

☐ *Acid Reflux (GERD)*
☐ *ADD*
☐ *ADHD*
☐ *AIDS/HIV Positive*
☐ *Alzheimer's Disease*
☐ *Anaphylaxis*
☐ *Anemia*
☐ *Angina*
☐ *Arthritis/Gout*
☐ *Artificial Heart Valve*
☐ *Artificial Joint*
☐ *Asthma*
☐ *Blood Disease*
☐ *Convulsions*
☐ *Cortisone Medicine*
☐ *Diabetes*
☐ *Drug Addiction*
☐ *Easily Winded*
☐ *Emphysema*
☐ *Epilepsy or Seizures*
☐ *Excessive Bleeding*
☐ *Excessive Thirst*
☐ *Fainting Spells/Dizziness*
☐ *Frequent Cough*
☐ *Frequent Diarrhea*
☐ *Frequent Headaches*
☐ *Heart Trouble/Disease*
☐ *Hemophilia*
☐ *Hepatitis A*
☐ *Hepatitis B or C*
☐ *Herpes*
☐ *High Blood Pressure*
☐ *Hives or Rash*
☐ *Hypoglycemia*
☐ *Irregular Heartbeat*
☐ *Kidney Problems*
☐ *Leukemia*
☐ *Liver Disease*
☐ *Low Blood Pressure*
☐ *Recent Weight Loss*
☐ *Renal Dialysis*
☐ *Rheumatic Fever*
☐ *Rheumatism*
☐ *Scarlet Fever*
☐ *Sexually Transmitted Disease*
☐ *Shingles*
☐ *Sickle Cell Disease*
☐ *Sinus Trouble*
☐ *Spina Bifida*
☐ *Stomach/Intestinal Disease*
☐ *Stroke*
☐ *Swelling of Limbs*

Patient Information Form cont.

Do you have, or have you had, any of the following?

- ☐ *Blood Transfusion*
- ☐ *Breathing Problem*
- ☐ *Bruise Easily*
- ☐ *Cancer*
- ☐ *Chemotherapy*
- ☐ *Chest Pains*
- ☐ *Cold Sores/Fever Blisters*
- ☐ *Congenital Heart Disorder*
- ☐ *Genital Herpes*
- ☐ *Glaucoma*
- ☐ *Hay Fever*
- ☐ *Hearing Impairment*
- ☐ *Heart Attack/Failure*
- ☐ *Heart Murmur*
- ☐ *Heart Pace Maker*
- ☐ *Lung Disease*
- ☐ *Mitral Valve Prolapse*
- ☐ *Organ Recipient*
- ☐ *Pain in Jaw Joints*
- ☐ *Parathyroid Disease*
- ☐ *Psychiatric Care*
- ☐ *Radiation Treatments*
- ☐ *Thyroid Disease*
- ☐ *Tonsillitis*
- ☐ *Tuberculosis*
- ☐ *Tumors or Growths*
- ☐ *Ulcers*
- ☐ *Venereal Disease*
- ☐ *Yellow Jaundice*

Anything not listed above? Please explain.

_____

_____

_____

Dental Health Information

Reason for today's visit? _____

Date of Last Dental Exam _____ / _____ / _____

Name of previous dentist? _____

Why did you leave your last dental office? _____

How often do you brush your teeth? _____ Floss? _____

What texture brush do you have? ☐ *Soft* ☐ *Medium* ☐ *Hard*

Are your teeth sensitive to: ☐ *Heat* ☐ *Cold* ☐ *Sweets* ☐ *Biting Pressure*

Do you experience stress, anxiety or fear when you visit a dental office? ☐ *Yes* ☐ *No*

Do you feel frustrated when you visit the dentist and always need treatment or repairs? ☐ *Yes* ☐ *No*

Do your gums bleed while brushing or flossing? ☐ *Yes* ☐ *No*

Do you ever have an unpleasant odor or taste in your mouth? ☐ *Yes* ☐ *No*

Do your gums ever feel tender and/or swollen? ☐ *Yes* ☐ *No*

Have your ever been treated for periodontal disease (gum disease, pyorrhea)? ☐ *Yes* ☐ *No*

Do you ever have pain in your jaw, ear or the side of your face? ☐ *Yes* ☐ *No*

Do you ever have difficulty opening or closing your mouth? ☐ *Yes* ☐ *No*

Do you ever experience any clicking or popping in your jaw? ☐ *Yes* ☐ *No*

Do you experience an unusual amount of headaches? ☐ *Yes* ☐ *No*

Do you clench or grind your teeth during the day or at night? ☐ *Yes* ☐ *No*

Do you feel that you are under an unusual amount of stress? ☐ *Yes* ☐ *No*

Do you snore while sleeping? ☐ *Yes* ☐ *No*

Do you feel unusually tired after a good night's sleep? ☐ *Yes* ☐ *No*

Have you ever had any teeth removed? ☐ *Yes* ☐ *No*

If so, how long ago? _____

Have you ever chipped or broken a tooth? ☐ *Yes* ☐ *No*

Have you ever experienced any injury or trauma to your teeth or face? ☐ *Yes* ☐ *No*

Do you gag easily? ☐ *Yes* ☐ *No*

Have you ever had orthodontic treatment (braces)? ☐ *Yes* ☐ *No*

If so, how long ago? _____

Do you drink products with caffeine? ☐ *Yes* ☐ *No*

Do you drink juice, soda, sports drinks? ☐ *Yes* ☐ *No*

Do you smoke or use tobacco products? ☐ *Yes* ☐ *No*

Home water is fluoridated? ☐ *Yes* ☐ *No*

Is there anything that would prevent you from doing any necessary treatment to restore your teeth to optimal health? ☐ *Yes* ☐ *No*

If yes, please explain: _____

Patient Information Form cont.

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions 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 my or patient's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examinations rendered to me or my child during the period of such dental care to third party payers and/or health practitioners.

I agree to be responsible for all charges for dental services and materials not paid by my benefit plan, unless prohibited by law, or the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the dentist or dental group. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Parent/Guardian/Subscriber Signature _____

Print _____ Date _____ / _____ / _____