## Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married (spouse)_____ ☐ Single ☐ Child ☐ Other _____

Birth Date:_____Social Security #:_____ Previous Visit: _____

Email address: _____ Best time to call: _____

Phone (Home): _____(Cell): _____ (Work):_____ Ext:_____

Address: _____
Street Apartment #

_____
City State Zip Code

**Person responsible for this account** _____Relationship_____

Address if different than above_____

Name and phone # of person to contact in the case of an emergency:_____

## Health Information

Date of Last Dental Visit: _____ Chief Dental Complaint:_____

**Have you ever had any of the following? Please check those that apply:**

☐ AIDS/HIV
☐ Allergies _____
- ☐ Sulfa/ sulfites
- ☐ Codeine Allergy
- ☐ Latex Allergy
- ☐ Penicillin Allergy

☐ Arthritis
☐ Asthma
☐ Bisphosphonate treatment (oral of IV)
☐ Blood Disorders
- ☐ Anemia
- ☐ Hemophilia

☐ Blood Thinners
☐ Cancer
Type _____
Date _____
☐ Chronic Obstructive Pulmonary Disease
☐ Diabetes
- ☐ Type 1
- ☐ Type 2

☐ Dizziness/Fainting
☐ Epilepsy
☐ Excessive Bleeding
☐ Glaucoma
☐ Hay Fever
☐ Head Injuries
☐ Hearing Impairment
☐ Heart Disease
☐ Heart Murmur
☐ Heart Attack
Date _____
☐ Pacemaker/DiFib
☐ Hepatitis (A, B or C?)
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Memory/Cognitive Issue
- ☐ Dementia
- ☐ Alzheimer's Disease
- ☐ Other _____

☐ Mental Health
- ☐ Anxiety/Depression
- ☐ ADHD
- ☐ Other _____

☐ Migraines
☐ Nervous Disorder
- ☐ Multiple Sclerosis
- ☐ Parkinson's
- ☐ Other _____

☐ Electrode Implants
☐ Osteoporosis
☐ Recreational Drug Use
☐ Sinus Problems
☐ Sleep Apnea
☐ Stomach Problems
☐ Stroke
☐ Thyroid Problems
☐ Tobacco/Marijuana Use
- ☐ Chew
- ☐ Smoke
- ☐ Vape/E-Cig

☐ TMJ
☐ Total Joint Replacement
☐ Tuberculosis
☐ Venereal Disease
☐ Vision Impairment
☐ Other _____

**For Women:**
☐ **Pregnancy**
Due date:_____
Nursing:_____
☐ Birth Control

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of Physician: _____ Phone:_____
- Does your physician recommend premedication before dental treatment? ☐ Yes ☐ No
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you been hospitalized in the last 6 months? ☐ Yes ☐ No
  If yes, please explain:_____
- Please list all current medications._____

_____

- Do you drink alcohol, if so how much & how often? _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date:_____
Signature of patient, parent or guardian

The best number to reach me is:_____ _____on my ☐ Home phone ☐ Work phone ☐ Cell phone

**PLEASE CONTINUE ON THE OTHER SIDE**

## Referral Information

Name of person or office referring you to our practice_____

## SPOUSE AND INSURANCE INFORMATION

**Primary**

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
(Last / First / MI)

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address:_____
(Street / City / State / Zip Code)

Insured's Employer Name:_____Phone #_____

Address:_____
(Street / City / State / Zip Code)

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address:_____

_____

**Secondary**

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
(Last / First / MI)

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address:_____
(Street / City / State / Zip Code)

Insured's Employer Name:_____

Address:_____
(Street / City / State / Zip Code)

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address:_____

_____

## Consent Statement

I hereby authorize and request the performance of dental services for myself or for: _____

_____

I also give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or his supervised staff for diagnostic purposes or dental treatment. These records may include study models, photographs, x-rays, and blood studies. *I understand and acknowledge that I am financially responsible for the services provided for myself or the above named, regardless of insurance coverage.* Treatment plans involving extended credit circumstances are subject to a credit check. I also understand that the treatment estimate presented to me is only an estimate. Occasionally, the need may arise to modify treatment, and in such a case, I will be informed of the need for additional treatment, and its fee modification. **I understand this office will help me utilize my insurance benefits. Ultimately I am responsible for my knowing my insurance plan and paying all balances left after insurance pays.** We may report information about your account to credit bureaus. Late payments, missed payments, or other defaults on you account may be reflected in your credit report.

I understand I will be charged $35.00 for all failed appointments without 24 hours notice.

To the best of my knowledge the information provided in this form is accurate.

_____ _____
Signature of patient, parent or guardian Date

Patient or guardian received Notice of Privacy Practices _____ _____
Date Initials

Completed forms can be returned by fax (509-232-0555), e-mail (info@braundentalcare.com), or in person. We look forward to seeing you soon!