Bryant
FAMILY DENTISTRY

PATIENT INFORMATION & HEALTH HISTORY:

Name: _____ Date: _____

Date of Birth: _____ Age: _____

Social Security #: _____ Email Address: _____

Home Phone #: _____ Cell Phone #: _____

Home Address: _____

_____
City State Zip

Employer & Position: _____ # of Years in Current Position: _____

Marital Status: _____Spouse's Name: _____Spouse's Date of Birth: _____

Spouse Employer: _____ Number of Years in Current Position: _____

Spouse's Social Security #: _____ Who will pay for this account? _____

Name of your Dental Insurance Company: _____

Whom may we thank for referring you? _____

Authorization & Release:

I certify that I have read and understand the following information to the best of my knowledge. The questions have been accurately answered to the best of my ability. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist the insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for my services.

I AGREE TO BE RESPONSIBLE FOR THE TOTAL PAYMENT FOR ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS, REGARDLESS OF WHAT MY INSURANCE COMPANY PAYS. I AGREE TO BE RESPONSIBLE FOR ANY FEES INCURRED SHOULD MY ACCOUNT BECOME DELINQUENT. THIS INCLUDES A 40% COLLECTION FEE AND ATTORNEY/COURT COSTS SHOULD THEY BE NECESSARY FOR COLLECTION OF MY DEBT.

Patient, Parent, or Guardian's Signature: _____

MEDICAL HISTORY:

Your medical history plays an important role in the health of your mouth and can determine the safety and effectiveness of anesthetics and other medications used for your dental treatment.

Please take the time to carefully and accurately answer the following questions.

Your Physician's Name: _____ Date of Last Exam: _____

Do you have any of the following medical conditions?

___ Any heart problems
___ Any surgeries
___ Diabetes
___High Blood Pressure
___ Allergies to medicines or drugs
(Penicillin, etc.)
___ Hepatitis
___ Sinus issues
___ Low Blood Pressure
___ Cancer
___ Stroke
___ Circulatory Problems
___ Allergies to _____
___ Autoimmune Disorder
___ Anemia
___ Tonsillitis
___ Radiation Treatments
___ Arthritis
___ Psychiatric Care
___ Tuberculosis
___ Excessive Bleeding
___ Asthma
___ Ulcers
___HIV/AIDS
___ Mitral Valve Prolapse
___ Are you pregnant?
___ Smoking/Tobacco Use
___ Artificial Joints
___ Alcohol Use
___ Osteoporosis

Please **list all medications** you are currently taking and **describe any current or upcoming medical treatments** or operations.

_____
_____
_____
_____
_____

Signature: _____ Date: _____

DENTAL Q & A:

Are you having any pain or discomfort at this time? _____

Do you have any concerns about your smile or oral health? _____

Do you fear dental treatment? _____

When was the last time you saw a dentist? _____