

WELCOME TO BRYAN DENTAL GROUP

WE ARE HAPPY TO HAVE YOU IN OUR OFFICE TODAY. PLEASE COMPLETE BOTH PAGES OF THIS FORM TO HELP US SERVE YOU BETTER.

Today's Date _____

How did you hear about us? _____

PATIENT INFORMATION

Name _____

First Middle Initial Last

Mailing Address _____

City State Zip

Home Telephone # _____

Cell Telephone # _____

I prefer to receive calls: Home Work Cell

Male Female SS# _____

Date of Birth _____ Age _____

Single Married Widowed Divorced Separated

Employer _____

Employer Telephone # _____

Spouse's Name _____

Spouse's Employer _____

DENTAL INSURANCE

Primary Dental Insurance

Name of Insured _____

SS# of Insured _____

Birthdate of Insured _____

Employer of Insured _____

Insurance Carrier _____

Insurance covers Self Spouse Children only Family

Secondary Dental Insurance

Name of Insured _____

SS# of Insured _____

Birthdate of Insured _____

Employer of Insured _____

Insurance Carrier _____

Insurance covers Self Spouse Children only Family

College Student Status Full-Time Part-Time

MINOR CHILD INFORMATION

Father's Name _____

Address (if different from child's) _____

Home Telephone # _____

Date of Birth _____ SS# _____

Employer _____

Employer Telephone # _____

Insurance for minor/child? Yes No

Is coverage? Primary Secondary

Insurance Carrier _____

Name of party responsible for making appointments for minor child _____

Mother's Name _____

Address (if different from child's) _____

Home Telephone # _____

Date of Birth _____ SS# _____

Employer _____

Employer Telephone # _____

Insurance for minor/child? Yes No

Is coverage? Primary Secondary

Insurance Carrier _____

AUTHORIZATION AND RELEASE

I have read and answered all questions to the best of my knowledge. I authorize Bryan Dental Group to release all information necessary to secure the payment of insurance benefits. I am financially responsible for all charges whether or not there is insurance coverage.

Signature of patient or parent if minor

Date

CONFIDENTIAL MEDICAL & DENTAL HISTORY

PATIENT NAME _____ **DATE OF BIRTH** _____

- | Y | N | CONDITIONS |
|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol Abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies/Hay Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina Pectoris |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Joint Replacement |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Heart Valve |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Transfusion |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer/Chemotherapy |
| <input type="checkbox"/> | <input type="checkbox"/> | COPD |
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital Heart Defect |
| <input type="checkbox"/> | <input type="checkbox"/> | Cosmetic Surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Breathing |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug Abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Seizures/Fainting |

- | Y | N | CONDITIONS |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A/B/C |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV+ AIDS Infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Leukemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse |
| <input type="checkbox"/> | <input type="checkbox"/> | Oral IV Bisphosphonates |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Pace Maker |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy |

- | Y | N | CONDITIONS |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcers/Stomach Problems |

Y	N	ALLERGIES
<input type="checkbox"/>	<input type="checkbox"/>	Aspirin
<input type="checkbox"/>	<input type="checkbox"/>	Codeine
<input type="checkbox"/>	<input type="checkbox"/>	Erythromycin
<input type="checkbox"/>	<input type="checkbox"/>	Latex
<input type="checkbox"/>	<input type="checkbox"/>	Penicillin
<input type="checkbox"/>	<input type="checkbox"/>	Sulfa
<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline
		Other _____

- Are you under the care of a medical doctor? NO YES, please explain

- Who is your medical doctor(s)? _____
- Have you ever had an operation or been hospitalized for a serious illness? NO YES, please explain

- Are you taking any pills, drugs or medication(s) including non-prescription medicine? NO YES, please explain

- If you require pre-medication for treatment, can we remind you by telephone or voice mail messages, post cards, etc.? If YES, please initial _____
- Have you ever taken cortisone or similar drugs? NO YES
- Have you ever experienced difficulty when anesthetics such as novocaine were administered? NO YES
(Drugs such as cocaine react negatively with novocaine.)
- Women only:
 - Are you pregnant or think you may be pregnant? NO YES Due date? _____
 - Are you nursing? NO YES
 - Are you taking oral contraceptives? NO YES

Signature of patient or parent if minor child _____ Date _____

OFFICE USE ONLY:
 Reviewed _____ Reviewed _____ Reviewed _____ Reviewed _____
 Reviewed _____ Reviewed _____ Reviewed _____ Reviewed _____