

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 # _____		
E-mail address _____		
Preferred Contact	<input type="checkbox"/> Telephone	<input type="checkbox"/> Text <input type="checkbox"/> E-mail
<input type="checkbox"/> Male <input type="checkbox"/> Female	SS# _____	
Date of Birth _____	Age _____	
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated		
Employer _____		
Employer Telephone # _____		
Spouse's Name _____		
Spouse's Employer _____		

DENTAL INSURANCE

Primary Dental Insurance	
Name of Insured _____	
SS# or ID# of Insured _____	
Birthdate of Insured _____	
Employer of Insured _____	
Insurance Carrier _____	
Insurance covers <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Children only <input type="checkbox"/> Family	
Secondary Dental Insurance	
Name of Insured _____	
SS# or ID# of Insured _____	
Birthdate of Insured _____	
Employer of Insured _____	
Insurance Carrier _____	
Insurance covers <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Children only <input type="checkbox"/> Family	
College Student Status	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time

MINOR CHILD INFORMATION

Father's Name _____	Mother's Name _____
Address (if different from child's) _____	Address (if different from child's) _____
_____	_____
Home Telephone # _____	Home Telephone # _____
Date of Birth _____ SS# _____	Date of Birth _____ SS# _____
Employer _____	Employer _____
Employer Telephone # _____	Employer Telephone # _____
Insurance for minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No	Insurance for minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is coverage? <input type="checkbox"/> Primary <input type="checkbox"/> Secondary	Is coverage? <input type="checkbox"/> Primary <input type="checkbox"/> Secondary
Insurance Carrier _____	Insurance Carrier _____
Name of party responsible for making appointments for minor child _____	

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 HEALTH 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 or 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
<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?
		Due date _____

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 _____

Current medications including non-prescription medicines:

- 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

- If you require pre-medication for treatment, can we remind you by telephone, voice mail messages, post cards, text messages, etc. If YES, please initial _____
- Have you ever experienced difficulty when anesthetics such as novocaine were administered? ~~NO~~ YES
(Drugs such as cocaine react negatively with novocaine.)

PATIENT SIGNATURE (PARENT IF MINOR CHILD) _____ **Date** _____

OFFICE USE ONLY:

Reviewed _____ Reviewed _____ Reviewed _____ Reviewed _____