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 ☐ Telephone ☐ Text ☐ E-mail

☐ 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# or ID# of Insured _____

Birthdate of Insured _____

Employer of Insured _____

Insurance Carrier _____

Insurance covers ☐ Self ☐ Spouse ☐ Children only ☐ Family

Secondary Dental Insurance

Name of Insured _____

SS# or ID# 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 _____

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 _____

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
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Acid Reflux/GERD
☐	☐	Allergies/Hay Fever
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Joint Replacement
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer/Chemotherapy
☐	☐	COPD
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy/Seizures/Fainting

Y	N	CONDITIONS
☐	☐	Glaucoma
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Heart Disease
☐	☐	Heart Murmur
☐	☐	Hemophilia
☐	☐	Hepatitis A/B/C
☐	☐	High Blood Pressure
☐	☐	HIV+ AIDS Infection
☐	☐	IBS
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Leukemia
☐	☐	Mitral Valve Prolapse
☐	☐	Oral or IV Bisphosphonates
☐	☐	Osteoporosis
☐	☐	Pace Maker
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy

Y	N	CONDITIONS
☐	☐	Respiratory Problems
☐	☐	Sleep Apnea
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tobacco, including chew
☐	☐	Tuberculosis
☐	☐	Ulcers/Stomach Problems
☐	☐	Are you pregnant?

Due date _____

Y	N	ALLERGIES
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Erythromycin
☐	☐	Latex
☐	☐	Penicillin
☐	☐	Sulfa
☐	☐	Tetracycline

Other

Current medications including non-prescription medicines or attach list:

_____

1. Are you under the care of a medical doctor? ☐ NO ☐ YES, please explain

   _____

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

   _____

4. In case of emergency, who should we call on your behalf?
   Name: _____ Relationship: _____ Phone: _____
5. If you require pre-medication for treatment, can we remind you by phone, voice mail, text messages, etc.
   If YES, please initial _____
6. Have you ever experienced difficulty when anesthetics such as novocaine were administered? NO ☐ YES ☐
   (Drugs such as cocaine react negatively with novocaine.)
7. Do you have a medical Power of Attorney (POA)? NO ☐ YES ☐ Are they currently your decision maker? NO ☐ YES ☐
   Named POA: _____ Phone: _____
8. List who we have permission to discuss your care:
   Name: _____ Relationship: _____ Phone: _____
   Name: _____ Relationship: _____ Phone: _____

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

OFFICE USE ONLY:

Reviewed _____ Reviewed _____ Reviewed _____ Reviewed _____