

We are complimented that you have selected us to provide dental care for you and your family.

Brookville Dental Patient Information

Date _____

Patient's Name _____
Last First Middle Marital Status

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Social Security # _____

Cell Phone _____ Email Address _____

Are you a full time student ____ Y ____ N Name of school _____

Employer _____ Occupation _____ No. years Employed _____

Employer Address _____ Work Phone _____

Name of nearest relative not living with you _____ Phone # _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

(If different from above)

Name _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 years) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Employer Address _____

Primary Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____ Birthdate _____

Insurance Company _____ Group No. _____ I.D.# _____

Insurance Co. Address _____ Ph. # _____

Insured's Employer _____ Ph. # _____

Secondary Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____ Birthdate _____

Insurance Company _____ Group No. _____ I.D.# _____

Insurance Co. Address _____ Ph. # _____

Insured's Employer _____ Ph. # _____

Dental Information

Previous Dentist: _____ Address/Phone # _____

Date of last dental x-rays: _____ How often do you brush? _____ How often do you floss? _____

Indicate which of the following you have had or have at present. Circle yes or no to each item.

Cigarette, pipe, or cigar smoking	YES NO	Bleeding gums	YES NO	Migraine headaches	YES NO
Chewing tobacco	YES NO	Swollen or tender gums	YES NO	Loose teeth	YES NO
Blisters on lips or mouth	YES NO	Periodontal treatment	YES NO	Broken fillings	YES NO
Burning sensation on tongue	YES NO	Mouth breathing	YES NO	Sensitivity to cold	YES NO
Mouth sores or growths	YES NO	Grinding teeth	YES NO	Sensitivity to hot	YES NO
Bad breath	YES NO	Jaw pain or tiredness	YES NO	Sensitivity to sweets	YES NO
Dry mouth	YES NO	Ear pain	YES NO	Sensitivity when biting	YES NO

Do you like the appearance of your teeth? YES NO

Reason for today's visit: _____

Medical Information

1. Are you having pain or discomfort at this time? YES NO
2. Have you been a patient in the hospital during the past two years? YES NO
3. Have you been under the care of a medical doctor during the past two years? YES NO
- Physician's Name _____ Phone No. _____
- Address _____
4. Have you taken any medication or drugs during the past two years? YES NO
5. Are you now taking any medication or drugs? YES NO
- If yes, please list: _____
6. Are you sensitive or allergic to any medication or anesthetics? YES NO
- If yes, please list: _____
7. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item
- | | | | | | | | | |
|------------------------------------|-----|----|---|-----|----|-------------------------------------|-----|----|
| Heart Failure | YES | NO | Artificial Joints (hip, knee, etc.) | YES | NO | Chicken Pox | YES | NO |
| Heart Disease or Attack | YES | NO | Kidney Trouble | YES | NO | Venereal Disease | YES | NO |
| Angina Pectoris | YES | NO | Ulcers | YES | NO | Human Papilloma Virus | YES | NO |
| Congenital Heart Disease | YES | NO | Diabetes | YES | NO | H.I.V. Positive/AIDS | YES | NO |
| Heart Murmur | YES | NO | Thyroid Problems | YES | NO | Cold Sores/Fever Blisters | YES | NO |
| High Blood Pressure | YES | NO | Glaucoma | YES | NO | Blood Transfusion | YES | NO |
| Arteriosclerosis | YES | NO | Cancer | YES | NO | Hemophilia | YES | NO |
| Mitral Valve Prolapse | YES | NO | Emphysema | YES | NO | Anemia | YES | NO |
| Artificial Heart Valve | YES | NO | Chronic Cough | YES | NO | Sickle Cell Disease | YES | NO |
| Heart Pacemaker | YES | NO | Tuberculosis | YES | NO | Bruise Easily | YES | NO |
| Heart Surgery | YES | NO | Asthma | YES | NO | Liver Disease | YES | NO |
| Rheumatic Fever | YES | NO | Hay Fever | YES | NO | Yellow Jaundice | YES | NO |
| Arthritis | YES | NO | Allergies or Hives | YES | NO | Epilepsy or Seizures | YES | NO |
| Rheumatism | YES | NO | Sinus Trouble | YES | NO | Fainting or Dizzy Spells | YES | NO |
| Cortisone Medicine | YES | NO | Radiation Therapy | YES | NO | Nervousness | YES | NO |
| Drug Addiction | YES | NO | Chemotherapy | YES | NO | Tumors | YES | NO |
| Stroke | YES | NO | Hepatitis A, B, C | YES | NO | Developmentally Disabled | YES | NO |
8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? YES NO
9. Do your ankles swell during the day? YES NO
10. Have you lost or gained more than 10 pounds in the past year? YES NO
11. Do you ever wake up from sleep and feel short of breath? YES NO
12. Are you on a special diet? YES NO
13. Do you have or have you had any disease, condition, or problem not listed? YES NO
- If yes, please list: _____

FOR WOMEN ONLY:

Are you pregnant? ☐ Yes, what month? _____ ☐ No Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____

CONSENT

- The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
- I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
- I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 - 1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges.
- I authorize my insurance company to pay benefits directly to Brookville Dental Associates.
- I understand that where appropriate, credit bureau reports may be obtained.
- I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

FOR OFFICE USE. Reviewed by Dr. _____ Date _____