WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to Help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

ABOUT YOU

Today's Date: _____

Email Address: _____

Name: _____
Last First MI Mr/Mrs/Ms/Dr

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: ___/___/___ Age: ____ SS#_____

Home Address:_____

_____
City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #:(___)_____ Cell #:_____

Wk #:(___)_____ Ext: ___ DL #:_____

Employer:_____

Whom may we thank for referring you?

_____

_____

Other family members seen by us:

_____

_____

EMERGENCY INFORMATION

His/Her Name:_____

Employer:_____

Wk #:(___)_____ Ext:___

Wk #:(___)_____ Ext:___

INSURANCE

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #:(___)_____

Group # (Plan, Local or Policy #):_____

Insured's Name:_____

Relation: _____

Insured's Birthday ___/___/_____

Insured's ID #:_____

Insured's Employer:_____

Person Responsible for Account:

Wk #:(___)_____ Ext:___ Hm #:(___)_____

Billing Address:_____

Relationship:_____

MEDICAL HISTORY

Are you currently under the care of a physician?

☐ Yes ☐ No

Please Explain: _____

_____

_____

_____

_____

_____

MEDICAL HISTORY, Cont.

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Do you smoke or use tobacco in any form?

☐ Yes ☐ No

Have you had any metal rods, pins, or implants?

☐ Yes ☐ No

Are you taking any prescription/over-the-counter or herbal supplement drugs? ☐ Yes ☐ No

Please list each one: _____

_____

_____

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No Week #:_____

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding
Y N Alcohol/Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones/Joints/Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Colitis
Y N Congenital Heart Disease
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N Herpes/Fever Blisters
Y N High Blood Pressure
Y N HIV+/AIDS
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Pressure
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic/Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease/Traits
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Penicillin
Y N Tetracyclene
Y N Other

Please list any other drugs/materials that you are allergic to:_____

_____

DENTAL HISTORY

Why have you come to the dentist today? _____

_____

_____

Do you require antibiotics berfore dental treatment?

☐ Yes ☐ No

Are you currently in pain?

☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous work?

☐ Yes ☐ No

Have you now or have you ever had gum treatment?

☐ Yes ☐ No

Do you now or have you ever experienced pain/discomfort in your jaw (TMJ/TMD?)

☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Are you sensitive to heat, cold, or anything else?

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____
Signature Date

Payment is due in full at the time of treatment
Unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of my group insurance benefits directly to BR Dental Care. I understand that I am responsible for all the costs of dental treatment. I hereby authorize the release of any information, including the diagnosis and records of treat ment or examination rendered, to my insurance company.

_____
Signature Date

GENERAL CONSENT FOR DENTAL TREATMENT

We are required to obtain your consent for the proposed dental treatment or oral surgery. Please read this form carefully, and we encourage you to ask us anything that you do not understand. We will be glad to explain it to you.

I hereby authorize and direct B.R. Dental Care and its staff to perform upon me or my child, _____, the following dental treatment or oral surgical procedures including the necessary or advisable local anesthesia, radiographs, or diagnostic aids.

In general terms, the dental procedures may include one or a number of the following:

- Cleaning of teeth and application of topical fluoride
- Treatment of periodontal disease with deep cleaning, gum surgery, and bone/soft tissue grafting
- Application of sealants to the grooves of teeth
- Treatment of diseased or injured teeth with dental restorations, either amalgam (silver) or composite (white)
- Stainless steel crowns for children, which are necessary in cases where simple fillings would not be the best long term restoration or in cases where there are large cavities.
- The replacement of missing teeth with a dental prosthesis (crowns, bridges, partial / complete dentures etc.)
- Extraction (removal) of one or more teeth that cannot be saved
- Treatment of diseased or injured oral tissues (hard and / or soft)
- Treatment of overlapped teeth and / or developmental abnormalities
- The use of sedative medications and / or nitrous oxide to control apprehension and anxiety

I understand that none of the above procedures will be performed without discussing the necessity with me and obtaining my consent to proceed. Alternative methods of treatment, if any, along with their advantages and disadvantages have been explained to me. I am advised that good results are expected; however, the possibility of complications cannot be accurately anticipated. Therefore, no guarantee expressed or implied, can be given to me regarding this treatment. I fully understand and authorize the doctor to perform any necessary treatment that in his / her judgment will be in the best interest of my or my child's health, once treatment has begun.

Although their occurrence is rare and unpredictable, some risks are known to be associated with dental or oral surgical procedures, medication, and / or anesthetics. We are required to disclose the known risks of numbness, infection, aspiration (swallowing), swelling, bleeding, discoloration, nausea, vomiting, allergic reaction, the loss of function of organs, and scarring. I understand and accept that complications may require medical assistance and hospitalization.

I also understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the gums and teeth that were not discovered during examination. The most common being the need for root canal therapy following routine restorative procedures. I give my permission to the dentist to make any / all changes and additions as necessary.

I certify that I have read and fully understand this consent. I have been given the opportunity to ask questions regarding this consent and proposed treatment. I also understand that this consent will remain in effect until such time I choose to terminate. Such termination of consent must be in writing.

_____
Date

_____
Patient / Parent / Guardian Signature

_____
Witness