bdc
Brewer Dental Center

Today's Date:

Patient's Name	**Sex** ☐ Male ☐ Female	Date of Birth / /	Social Security Number:
Address (Street & Apartment #)	**Patient Is:** □ Minor □ Married □ Single □ Student □Widowed	Home Phone ( )	Cell Phone: ( )
Address (City, State & Zip)		Employed □ Full Time □ Part Time □ Other	Employer:
Email:		Emergency Contact:	Employer Phone: ( )
Spouse's or Parent's Name (If patient is a minor)		Emergency Contact Phone: ( )	How Did You Hear About Our Office?

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	O Yes	O No	If yes _____
Have you ever been hospitalized or had a major operation?	O Yes	O No	If yes _____
Have you ever had a serious head or neck injury?	O Yes	O No	If yes _____
Are you taking any medications, pills, or drugs?	O Yes	O No	If yes _____
Do you take, or have you taken, Phen-Fen or Redux?	O Yes	O No	If yes _____
Have you ever taken Fosamax, Boniva, Actenol or any other medications containing bisphosphonates?	O Yes	O No	If yes _____
Do you take any arthritis medications?	O Yes	O No	If yes _____
Do you currently take blood thinners?	O Yes	O No	If yes _____
Do you require a pre-medication?	O Yes	O No	If yes _____
Are you on a special diet?	O Yes	O No	If yes _____
Do you use any form of tobacco?	O Yes	O No	If yes _____
Do you use controlled substances?	O Yes	O No	If yes _____

Women: Are you
___Pregnant? If yes, due date?_____ ___Trying to get pregnant? ___ Nursing?
___Are you using contraceptives?

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?
__Aspirin __Penicillin ___Codeine ___Acrylic ___Metal ___Latex __Sulfa Drugs ___Local Anesthetics
___Other allergies? O Yes O No If yes _____

Do you have, or have you had, any of the following?

Acid Reflux	O Yes	O No	Cortisone Medicine	O Yes	O No	Hepatitis A	O Yes	O No	Renal Dialysis	O Yes	O No
AIDS/HIV Positive	O Yes	O No	Diabetes	O Yes	O No	Hepatitis B or C	O Yes	O No	Rheumatic Fever	O Yes	O No
Alzheimer's Disease	O Yes	O No	Drug Addiction	O Yes	O No	High Blood Pressure	O Yes	O No	Rheumatism	O Yes	O No
Anaphylaxis	O Yes	O No	Easily Winded	O Yes	O No	High Cholesterol	O Yes	O No	Scarlet Fever	O Yes	O No
Anemia	O Yes	O No	Emphysema	O Yes	O No	Hives or Rash	O Yes	O No	Shingles	O Yes	O No
Angina	O Yes	O No	Epilepsy or Seizures	O Yes	O No	Hypoglycemia	O Yes	O No	Sickle Cell Disease	O Yes	O No
Arthritis/Gout	O Yes	O No	Excessive Bleeding	O Yes	O No	Irregular Heartbeat	O Yes	O No	Sinus Trouble	O Yes	O No
Artificial Heart Valve	O Yes	O No	Excessive Thirst	O Yes	O No	Kidney Problems	O Yes	O No	Sleep Apnea	O Yes	O No
Artificial Joint	O Yes	O No	Fainting Spells/Dizziness	O Yes	O No	Leukemia	O Yes	O No	Spina Bifida	O Yes	O No
Asthma	O Yes	O No	Frequent Cough	O Yes	O No	Liver Disease	O Yes	O No	Steroids	O Yes	O No
Blood Disease	O Yes	O No	Frequent Diarrhea	O Yes	O No	Low Blood Pressure	O Yes	O No	Stomach/Intestinal Disease	O Yes	O No
Blood Transfusion	O Yes	O No	Frequent Headaches	O Yes	O No	Lung Disease	O Yes	O No	Stroke	O Yes	O No
Breathing Problem	O Yes	O No	Glaucoma	O Yes	O No	Mitral Valve Prolapse	O Yes	O No	Swelling of Limbs	O Yes	O No
Bruise Easily	O Yes	O No	Hay Fever	O Yes	O No	Osteoporosis	O Yes	O No	Tonsillitis	O Yes	O No
Cancer	O Yes	O No	Heart Attack/Failure	O Yes	O No	Pain in Jaw Joints	O Yes	O No	Trouble Sleeping	O Yes	O No
Chemotherapy	O Yes	O No	Heart Murmur	O Yes	O No	Parathyroid/Thyroid Disease	O Yes	O No	Tuberculosis	O Yes	O No
Chest Pains	O Yes	O No	Heart Pacemaker	O Yes	O No	Psychiatric Care	O Yes	O No	Tumors or Growths	O Yes	O No
Cold Sores/Fever Blisters	O Yes	O No	Heart Trouble/Disease	O Yes	O No	Radiation Treatments	O Yes	O No	Ulcers	O Yes	O No
Congenital Heart Disorder	O Yes	O No	Hemophilia	O Yes	O No	Recent Weight Loss	O Yes	O No	Yellow Jaundice	O Yes	O No
Convulsions	O Yes	O No									

Have you ever had any serious illness not listed above? O Yes O No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT or GUARDIAN_____DATE _____

Responsible Party:

Name:_____ Relationship to Patient:_____
Address:_____ City, State, Zip_____
DOB:_____ Phone: _____
Employer:_____ Employer Phone: _____

The following protected health information may be released to the above individual

____ Billing & Account information ____Treatment information

2nd Responsible Party:

Name:_____ Relationship to Patient:_____
Address:_____ City, State, Zip_____
DOB:_____ Phone: _____
Employer:_____ Employer Phone: _____

The following protected health information may be released to the above individual

____ Billing & Account information ____Treatment information

Dental Insurance Information

Name Of policy holder:_____ Relationship to Patient:_____
Policy Holder's Birth Date:_____/_____/_____ Policy Holder's SS#:_____
Insurance ID#:_____ Group #:_____
Insurance Company:_____ Phone #: ( )_____
Policy Holder's Employer: _____

Secondary Dental Insurance Information

Name Of policy holder:_____ Relationship to Patient:_____
Policy Holder's Birth Date:_____/_____/_____ Policy Holder's SS#:_____
Insurance ID#:_____ Group #:_____
Insurance Company:_____ Phone #: ( )_____
Policy Holder's Employer: _____

Financial Agreement

____ I understand payment is due at the time of service. If I have dental insurance I agree to pay my estimated out of pocket at the time of treatment.

____ I understand insurance is just an estimate and benefits are determined by the employer not Brewer Dental Center. It is my responsibility to understand my insurance plan.

____ I understand all balances over 60 days are subject to a 1.5% per month billing charge.

____ I agree I am responsible for notifying Brewer Dental Center of any insurance change I may encounter.

I hereby authorize and direct Brewer Dental Center, as assisted by other dentists and auxiliaries, to perform any necessary dental treatment.

All patients under the age of 18 must have a parent or legal guardian present for all scheduled appointments.

Patient/ Parent/ *Legal Guardian Signature: _____

Printed Name of Patient/ Parent/ *Legal Guardian: _____

Relationship to Patient:_____ Date: _____

**If signed by a patient's authorized representative, or legal guardian, supporting legal documentation must accompany this authorization form.*