BRIMHALL FAMILY DENTISTRY

WE ARE EXCITED TO HAVE YOU AS PART OF OUR DENTAL FAMILY! PLEASE TAKE A FEW MINUTES TO FILL OUT THIS FORM AS COMPLETELY AS YOU CAN.

Patient Information

Name:___________________________________ **Phone**: ________________________

Date:____________________ **Sex**: M____ F____ **Birth Date**: ______/______/____________

SSN: _________-_______-_____________ **Driver's License#**________________________

Child___ Single___ Married___ Widowed___ Separated___ Divorced___

Address:______________________________ **City**:________________ **State:**____ **Zip:**_______

Employed by:___________________________ **Occupation**:______________________

Has any other family members been here before?

Name____ **Relationship**___________________

If student, School name:____

Address_______________________ City:____________________ State:____ Zip:__________

Insurance Name:______________________________________**Telephone #**____________________

Identification #_________________________ **Group #:**____________________________

Whom may we thank for referring you? ____

In case of emergency who should be notified? ____

Phone#: ___________________________ Relationship:________________________________

If patient is a minor fill out next part

Responsible person:__________________________ **Relationship to Patient:**___________________

Birth Date:_____/____/________ **SSN**:_______-______-________ **Sex: M**___ **F**___

Phone #_______________________________________

Address______________________________ **City:**____________ **State:**_______ **Zip:**______

Employed by:___________________________ **Occupation:**______________________________

~NEXT PAGE~

Dental History

Reason for Today's Visit____

Date of last dental visit____________________________ Dentist Name:________________________

Check if you have had problems with any of the following:

____Bad Breath ____Grinding teeth ____Sensitivity to hot

____Bleeding gums ____Loose teeth ____Sensitivity to sweets

____Clicking or popping jaw ____Broken fillings ____Sensitivity when biting

____Food collection between teeth ____Sensitivity to cold ____Sores or growths in your mouth

How often do you floss? __________________________ How often do you brush? _________________

Medical History

Physician's Name_______________________________________ Date of Last Visit_______________

Have you had any serious illnesses or operations? If yes, describe____________________________

Have you ever had a blood transfusion? ___Yes ___No If yes, give approximate date_____________

List medications you are currently taking____

Are you allergic to any medication? ____

(Women) Are you pregnant? __Yes __No Nursing? __Yes __No Taking birth control pills? __Yes __No

Check if you have or have had any of the following:

___Anemia ___Cortisone Treatments ___Hepatitis ___Shortness of breath

___Arthritis, Rheumatism ___Cough, Persistent ___High Blood Pressure ___Skin Rash

___Artificial Heart Valves ___Diabetes ___HIV/AIDS ___Stroke

___Artificial Joints ___Epilepsy ___Jaw Pain ___Swelling

___Asthma ___Fainting ___Liver Disease ___Thyroid Problems

___Back Problems ___Glaucoma ___Kidney Disease ___Tobacco Habit

___Blood Disease ___Headaches ___Pacemaker ___Tonsillitis

___Cancer ___Heart Murmur ___Radiation Treatment ___Tuberculosis

___Chemotherapy ___Heart Problems ___Respiratory Disease ___Ulcer

___Circulatory Problems ___Hemophilia ___Rheumatic Fever ___Venereal Disease

********I understand that payment is due in full at time of treatment unless prior arrangements have been approved.**

Signature____ Date________________________________

(If patient is a child, parent signature is needed)