

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:** _____

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:

- | | | |
|--|--|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Broken fillings | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> 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:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> 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)