

PATIENT INFORMATION

Male Female

Dentist of Record: _____ (Office Use)

NAME: Last _____ First _____ MI _____ Prefer to be called: _____

BIRTHDATE: ____/____/____ Single Married (Anniversary: _____) Divorced Widowed Partner

E-MAIL ADDRESS: _____ (For Appointment Reminders/Confirmations)

We will not share, rent, or sell your e-mail address...ever.

I would like to receive TEXT Appointment Reminders/Confirmations.

PHONE: Cell _____ Home _____ Work _____

HOME: Address _____ City: _____ State: _____ Zip: _____

How did you hear about Brook West? Friend/Family: _____ Internet Other Please specify: _____

Full-Time Student? No Yes Name of School: _____

Hobbies: _____

PERSON RESPONSIBLE FOR BILLING/ACCOUNT

Responsible Party Name: _____ Relationship to Patient: _____

Soc Sec #: _____ Home Phone: _____ Work Phone: _____ Ext _____

Employer: _____ Employer Address: _____

Employer City: _____ State: _____ Zip: _____ Years with firm: _____

SPOUSE OR PARTNER INFORMATION RELATING TO PATIENT (IF APPLICABLE)

NAME : Last _____ First _____ Employer: _____

PHONE: Home: _____ Cell: _____ Work: _____ Ext: _____

EMPLOYER: Address: _____ City: _____ State: _____ Zip: _____

DENTAL INSURANCE

PRIMARY Subscriber's Name: _____ Birthdate: ____/____/____ ID/Soc Sec #: _____

Subscriber's Address _____ Phone: _____ Employer: _____

Insurance Company: _____ Group #: _____ Subscriber ID: _____

SECONDARY Subscriber's Name: _____ Birthdate: ____/____/____ ID/Soc Sec #: _____

Subscriber's Address _____ Phone: _____ Employer: _____

Insurance Company: _____ Group #: _____ Subscriber ID: _____

MEDICAL INSURANCE

Subscriber's Name: _____ Birthdate: ____/____/____ Soc Sec #: _____

Subscriber's Address _____ Phone: _____ Employer: _____

Insurance Company: _____ Group #: _____ Subscriber ID: _____

NEAREST RELATIVE (NOT LIVING WITH YOU)

Name : _____ Relationship: _____ Phone: _____

I CERTIFY THAT I/MY DEPENDENTS HAVE INSURANCE COVERAGE AND ASSIGN DIRECTLY TO BROOK WEST FAMILY DENTISTRY ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS.

RESPONSIBLE PARTY SIGNATURE: X _____ DATE: _____

MEDICAL HISTORY

YOUR NAME: Last _____ First _____ MI _____

YOUR PHYSICIAN _____ PHONE _____

FORMER DENTIST _____ PHONE _____

YES NO

1. Are you now under current, **medical treatment**? Explain _____
2. Have you had any recent, **medical surgery**? Explain _____
- 3a. **Medications**: Are you currently taking any medication? (List with **dosages/frequency** below **or** on a separate piece of paper.)

- 3b. **Medications**: Have you ever taken oral or IV Bisphosphonates for osteoporosis, cancer, or other conditions?
- 3c. **Medications**: Do you take aspirin or anticoagulants? Explain _____
4. Do you have **allergies**? (penicillin, codeine, sulfa, other) Explain _____
5. Do you have a **heart condition, heart murmur, or heart valve defect**? Explain _____
6. Do you have **circulatory** problems? (High/low blood pressure, etc.) Explain _____
7. Are you a **hemophiliac** or do you have **bleeding problems**? Explain _____
8. Are you (or could you be) **pregnant**? Due date _____
9. Have you ever had **radiation** treatment to the **head or neck**? Explain _____
10. Have you ever experienced **complications** with **healing**? Explain _____
11. Have you ever had hip or joint replacement? Date of surgery: _____

YES NO

- Blood disease (anemia, etc.)
- Nervous disorders (epilepsy, anxiety)
- Respiratory disorders (asthma, etc.)
- Arthritis or rheumatism
- Diabetes
- Smoker
- Latex sensitivity, metal sensitivity
- Sinus problems
- Chronic ear infections
- Thyroid problems
- Tooth sensitivity

YES NO

- Tuberculosis
- Anorexia, bulimia
- Rheumatic fever
- Tumors or growths
- Liver disease (jaundice, etc.)
- Kidney disease
- Serious head injuries
- Acquired immune deficiency syndrome (AIDS)
- Hepatitis type: _____
- Snoring/sleep apnea
- Other conditions: _____

I CERTIFY THIS MEDICAL INFORMATION TO BE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

PATIENT OR GUARDIAN SIGNATURE: X _____ Date: _____

To Update Information: I CERTIFY THIS MEDICAL INFORMATION TO BE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Patient or Guardian Signature: _____ Date: _____

Patient or Guardian Signature: _____ Date: _____

Patient or Guardian Signature: _____ Date: _____

Patient or Guardian Signature: _____ Date: _____