We are complimented that you have selected us to provide dental care for you and your family.

Brookville Dental Patient Information

Date _____

Patient's Name _____ (Last / First / Middle / Marital Status)

Address _____ (Street / City / State / Zip)

Home Phone _____ Birthdate _____ Social Security # _____

Cell Phone _____ Email Address _____

Are you a full time student ___ Y ___ N Name of school _____

Employer _____ Occupation _____ No. years Employed _____

Employer Address _____ Work Phone _____

Name of nearest relative not living with you _____ Phone # _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

(If different from above)

Name _____ (Last / First / Middle / Marital Status)

Residence _____ (Street / City / State / Zip)

Mailing Address _____ (Street / City / State / Zip)

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 years) _____ (Street / City / State / Zip)

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Employer Address _____

Primary Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____ Birthdate _____

Insurance Company _____ Group No. _____ I.D.# _____

Insurance Co. Address _____ Ph. # _____

Insured's Employer _____ Ph. # _____

Secondary Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____ Birthdate _____

Insurance Company _____ Group No. _____ I.D.# _____

Insurance Co. Address _____ Ph. # _____

Insured's Employer _____ Ph. # _____

Dental Information

Previous Dentist: _____ Address/Phone # _____

Date of last dental x-rays: _____ How often do you brush? _____ How often do you floss? _____

Indicate which of the following you have had or have at present. Circle yes or no to each item.

Cigarette, pipe, or cigar smoking	YES	NO	Bleeding gums	YES	NO	Migraine headaches	YES	NO
Chewing tobacco	YES	NO	Swollen or tender gums	YES	NO	Loose teeth	YES	NO
Blisters on lips or mouth	YES	NO	Periodontal treatment	YES	NO	Broken fillings	YES	NO
Burning sensation on tongue	YES	NO	Mouth breathing	YES	NO	Sensitivity to cold	YES	NO
Mouth sores or growths	YES	NO	Grinding teeth	YES	NO	Sensitivity to hot	YES	NO
Bad breath	YES	NO	Jaw pain or tiredness	YES	NO	Sensitivity to sweets	YES	NO
Dry mouth	YES	NO	Ear pain	YES	NO	Sensitivity when biting	YES	NO
Do you like the appearance of your teeth?	YES	NO						

Reason for today's visit: _____

Medical Information

1. Are you having pain or discomfort at this time? YES NO
2. Have you been a patient in the hospital during the past two years? YES NO
3. Have you been under the care of a medical doctor during the past two years? YES NO
   Physician's Name _____ Phone No. _____
   Address _____
4. Have you taken any medication or drugs during the past two years? YES NO
5. Are you now taking any medication or drugs? YES NO
   If yes, please list: _____
6. Are you sensitive or allergic to any medication or anesthetics? YES NO
   If yes, please list: _____
7. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item

Heart Failure	YES	NO	Artificial Joints (hip, knee, etc.)	YES	NO	Chicken Pox	YES	NO
Heart Disease or Attack	YES	NO	Kidney Trouble	YES	NO	Venereal Disease	YES	NO
Angina Pectoris	YES	NO	Ulcers	YES	NO	Human Papilloma Virus	YES	NO
Congenital Heart Disease	YES	NO	Diabetes	YES	NO	H.I.V. Positive/AIDS	YES	NO
Heart Murmur	YES	NO	Thyroid Problems	YES	NO	Cold Sores/Fever Blisters	YES	NO
High Blood Pressure	YES	NO	Glaucoma	YES	NO	Blood Transfusion	YES	NO
Arteriosclerosis	YES	NO	Cancer	YES	NO	Hemophilia	YES	NO
Mitral Valve Prolapse	YES	NO	Emphysema	YES	NO	Anemia	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough	YES	NO	Sickle Cell Disease	YES	NO
Heart Pacemaker	YES	NO	Tuberculosis	YES	NO	Bruise Easily	YES	NO
Heart Surgery	YES	NO	Asthma	YES	NO	Liver Disease	YES	NO
Rheumatic Fever	YES	NO	Hay Fever	YES	NO	Yellow Jaundice	YES	NO
Arthritis	YES	NO	Allergies or Hives	YES	NO	Epilepsy or Seizures	YES	NO
Rheumatism	YES	NO	Sinus Trouble	YES	NO	Fainting or Dizzy Spells	YES	NO
Cortisone Medicine	YES	NO	Radiation Therapy	YES	NO	Nervousness	YES	NO
Drug Addiction	YES	NO	Chemotherapy	YES	NO	Tumors	YES	NO
Stroke	YES	NO	Hepatitis A, B, C	YES	NO	Developmentally Disabled	YES	NO

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? YES NO
9. Do your ankles swell during the day? YES NO
10. Have you lost or gained more than 10 pounds in the past year? YES NO
11. Do you ever wake up from sleep and feel short of breath? YES NO
12. Are you on a special diet? YES NO
13. Do you have or have you had any disease, condition, or problem not listed? YES NO
    If yes, please list: _____
    _____

FOR WOMEN ONLY:
Are you pregnant? ☐ Yes, what month? _____. ☐ No Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____

CONSENT

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient)_____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 - 1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I authorize my insurance company to pay benefits directly to Brookville Dental Associates.
5. I understand that where appropriate, credit bureau reports may be obtained.
6. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

FOR OFFICE USE. Reviewed by Dr. _____ _____ Date