Emergency Dental Care USA - Patient Information and Medical History

Patient Information:

Patient Name: _____

Birth Date: _____ Age: _____ Male Female SS#_____

Home Address: _____City/State/Zip: _____

Home Phone #:_____ Work Phone: _____

Cell Phone #:_____ Employer: _____

Email address:_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

How did you hear about our office? _____

Emergency Contact Person: _____ Phone :_____

Responsible Party Information: (If ***not*** the patient please complete)

Parent or Spouse Name: (circle one) _____

Address: (if different from above) _____

Phone #:_____ Cell Phone #:_____ Is this person currently a patient? Y or N

Birth Date: _____SS#_____

Employer: _____ Work Phone: _____

Insurance Information: (If ***other than*** patient or responsible party please complete below)

Please Present office with your insurance card.

Insured's Name: _____ SS#:_____

Birth Date: _____ Phone: _____

Employer: _____ Work Phone #:_____

Do you have secondary coverage? Please present office with that insurance card as well.

Insured's Name: _____ SS#:_____

Birth Date: _____ Phone #:_____

Employer: _____ Work Phone #:_____

Authorization and Release

Our dental office will gladly assist you in filing your insurance claim, but we are unable to accept responsibility for collecting your claim if there is a dispute. It is your responsibility to pay for the entire amount not covered by your dental benefit plan. By signing this form, you hereby assign all payments for services provided for yourself or dependents to Brentwood Dental Group.

All accounts 30 days and over are past due and will be subject to an interest rate of 18% per annum. All collections 90 days past due may be turned over for collection. In the event, you or your insurance company fail to pay and it is necessary to employ outside collections efforts, you are responsible for reasonable costs for collection, including but not limited to court costs, attorney fees and collection agency fees.

_____

Responsible Party's Signature **Date**

Patient Medical History:

Physician's Name: _____ Phone #:_____ Date of last visit:_____

How long since your last: Dental Visit: _____ Cleaning: _____ X-rays:_____

1. Are you under medical treatment now? Yes No
2. Have you ever been hospitalized for any surgical operation or serious illness? Yes No
3. Are you taking any medication(s), including non-prescription medications or diet pills? Yes No
   Please List:
4. Do you use alcohol? Yes No Or Tobacco? Yes No
5. Are you wearing contact lens? Yes No
6. Are you allergic to or have any reactions to the following?

Local Anesthetics (e.g. Lidocaine)	Yes	No
Penicillin or other Antibiotics	Yes	No
Latex	Yes	No
Narcotic Drugs (e.g. Percodan)	Yes	No
Barbiturates	Yes	No
Sedatives	Yes	No
Aspirin	Yes	No
Metal or Other_____	Yes	No

7. Women Only:

Are you pregnant or think you may be pregnant	Yes	No
Are you nursing?	Yes	No
Are you taking birth control medications?	Yes	No

8. Do you have or have you had any of the following? (Explain below)

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Hay Fever/Allergies	☐	☐	Angina	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Respiratory Problems	☐	☐	Radiation Therapy	☐	☐	Anemia	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Recent Weight Loss/Gain	☐	☐	Cancer	☐	☐
Artificial Heart Valve	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Mitrovalve Prolapse	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Disease	☐	☐	Hepatitis/Jaundice	☐	☐	Asthma	☐	☐
AIDS/HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Diabetes	☐	☐
Thyroid Problems	☐	☐	Stomach Problems/Ulcers	☐	☐	Leukemia	☐	☐

Other: _____

Explanation: _____

Patient Dental History:

1. Do your gums bleed while brushing or flossing?
2. Are your teeth sensitive to hot or cold foods/liquids?
3. Are your teeth sensitive to sweet or sour foods/liquids?
4. Do you have any sores or lumps in or near your mouth?
5. Have you had any head or neck injuries?
6. Have you ever experienced any of the following problems in your jaw?
   Clicking
   Pain (joint, ear, side of face)
   Difficulty in opening or closing
   Difficulty in chewing
7. Do you have frequent headaches?
8. Do you clench or grind your teeth?
9. Have you ever had any difficult extractions?
10. Did you wear braces?
11. Have you had any prolong bleeding following an extraction
12. Have you ever had instruction on the correct method of brushing your teeth or care of your gums

I certify that I have completed the above information to the best of my knowledge.

Signature of Patient or Parent **Date**

Are there any changes in your medical history?			