

BRITER DENTAL

WELCOME

Thank you for selecting Briter Dental! To help us meet all of your health care needs, please complete this form as accurately as possible. Thank you!

1) PATIENT INFORMATION

This appointment is for Yourself Your Child

Patient Full Name _____ Social Security # _____
Birth Date _____ Age _____ Male Female Single Married Other
Driver's License # _____ State _____ Exp Date _____
Address _____ City _____ State _____ Zip _____
Full Time Student _____ Yes No School Name _____
Employer _____ Occupation _____
Previous Dentist _____ Previous Dentist Phone _____
Current Physician _____ Current Physician Phone _____

2) TELEPHONE & EMAIL

Home Phone _____ Work Phone _____ Cell Phone _____
Email _____ Best time to call _____
In the event of an emergency, who should we contact?
Name _____ Relationship _____
Home Phone _____ Work Phone _____

3) RESPONSIBLE PARTY

Who is responsible for this patient

Full Name _____ Social Security # _____
Birth Date _____ Age _____ Male Female
Address _____ City _____ State _____ Zip _____
Employer _____ Occupation _____
Home Phone _____ Work Phone _____

4) INSURANCE INFORMATION

Dental Coverage Yes No

Insured's Name _____ Relation _____
Insured's Social Security # _____ Birth Date _____
Insurance Group # _____ Insurance Policy # _____
Insurance Co. Name _____ Insurance Co Phone _____

5) DENTAL HISTORY

Why have you come to the dentist today? _____
Date of last Dental Visit: _____
Do you require premedication before dental treatment? Yes ___ No ___
Are you currently in pain? Yes ___ No ___
Do your gums ever bleed? Yes ___ No ___
Have you ever had difficulties associated with any previous dental work? Yes ___ No ___
Do you or have you ever experienced pain in your jaw joint (TMJ / TMD)? Yes ___ No ___
Have your tonsils or adenoids been removed? Yes ___ No ___
Do you floss on a regular basis? Yes ___ No ___

6) MEDICAL HISTORY

Do you consider yourself in good medical health? Yes___ No___
 Have you had previous skin reactions to jewelry or know of an allergy to any metal?..... Yes___ No___
 Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?..... Yes___ No___
 Have you been hospitalized or had a serious operation or illness within the last 5 years?..... Yes___ No___
 Are you taking any medications?..... Yes___ No___

If so, please list here? _____

Are you allergic to any of the following?

- | | | | |
|--|---------------------------------------|---|--|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Lidocaine or Marcaine |
| <input type="checkbox"/> Nitrous oxide gas | <input type="checkbox"/> Iodine | <input type="checkbox"/> Dental anesthetics | <input type="checkbox"/> Erythromycin |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Other: _____ | | |

Have you ever had any of the following medical problems? Please check those that apply:

- | | | |
|--|---|---|
| <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Fainting or Dizzy Spells | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Alcohol / Drug abuse | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Liver Disease / Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Nervous Disorder |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Heart Attack or Disease | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur / Surgery | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cancer or Leukemia | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Seizures or Epilepsy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Herpes / Fever Blisters | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> HIV Positive / AIDS | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Tumors | <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Implants | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Cough | <input type="checkbox"/> Bruise easily |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Cold Sores |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Hepatitis A (Infectious) | <input type="checkbox"/> Hepatitis B (Serum) | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Yellow Jaundice | <input type="checkbox"/> STD/ Syphilis, Gonorrhea | |
| <input type="checkbox"/> Other _____ | | |

Women only:

Are you currently pregnant?..... Yes___ No___

If so, how many weeks? _____

Are you nursing Yes___ No___

Are you taking birth control Yes___ No___

7) REFERRAL INFORMATION

Whom may we thank for referring you to our practice? Another patient Internet Pass by
 Yellow Book Katy ATT Yellow Pages Consolidated Phone book Other: _____

Name of person or office referring you to our practice: _____

8) ACKNOWLEDGEMENT & AUTHORIZATION

The undersigned hereby authorized Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorized Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated with (name of Patient) _____ and further authorize and consent that Doctor choose and employ such as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I certify that I have read and understand the above. I acknowledge that my questions have been answered truthfully and to the best of my knowledge. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

SIGNATURE _____ DATE _____

DOCTOR'S SIGNATURE _____ DATE _____