Welcome to Bruner Dental Center

Please fill out this form completely; it is important to your care.

ABOUT YOU

Today's Date: _____ Married Single Partnered Divorced Separated Widowed

Name: _____ M/F Birthday ____/____/____ Age:____ SS #:_____
LAST FIRST MI

Home Address: _____
CITY STATE ZIP

Hm #:(____)_____ Cell #:(____)_____ Wk #:(____)_____ DL #:_____

E-Mail Address:_____ When are the best times to reach you?_____

Whom may we thank for referring you?_____ Other family members seen by us: _____

Employer:_____ How long there?_____ Occupation _____

Employer's Address:_____
CITY STATE ZIP

General Doctor:_____ Previous or Present (Please circle) Date of last visit:_____

In the event of an emergency, whom should we contact?

His/Her Name:_____ Relation:_____ Wk #:(_____)_____

Hm #:(_____)_____ Address:_____
CITY STATE ZIP

SPOUSE INFORMATION

His/Her Name: _____ Birthdate:____/____/____ SS #:_____

Employer:_____ Wk #:(_____)_____ DL #:_____

Person Responsible for Account, if other than yourself

Name: _____ Relation:_____ SS #:_____

Employer:_____ Wk #:(_____)_____ DL #:_____

Hm #:(_____)_____ Billing Address:_____

INSURANCE INFORMATION

Primary Insurance Dental Coverage: Yes/No Medical Coverage: Yes/No Orthodontic Coverage: Yes/No

Ins. Co. Name:_____ Ins. Co. Ph. #:(_____)_____ Group #(Plan, Local or Policy #:_____

Ins. Co. Address:_____
CITY STATE ZIP

Insured's Name:_____ Relation:_____ Insured's Birthdate:____/____/____ SS #:_____

Insured's Employer:_____ Employer's Address:_____
CITY STATE ZIP

Secondary Insurance Dental Coverage: Yes/No Medical Coverage: Yes/No Orthodontic Coverage: Yes/No

Ins. Co. Name:_____ Ins. Co. Ph. #:(_____)_____ Group #(Plan, Local or Policy #:_____

Ins. Co. Address:_____
CITY STATE ZIP

Insured's Name:_____ Relation:_____ Insured's Birthdate:____/____/____ SS #:_____

Insured's Employer:_____ Employer's Address:_____
CITY STATE ZIP

HISTORY

Why have you come to the doctor today? _____

_____

- Are you currently in pain? Yes / No
- Do you require antibiotics before dental treatment? Yes / No
- Have you experienced problems associated with Yes / No
- any previous dental work?
- Do you now or have you ever experienced Yes / No pain/discomfort in your jaw (TMJ/TMD)?
- Your current dental health is: Good Fair Poor
- Do you floss daily: Yes / No Do you brush daily: Yes / No
- Type of bristles on toothbrush: Hard Medium Soft

How often do you replace your toothbrush? _____

Do you use anything in addition to your brush and floss? Yes / No

If yes, what? _____

Would you like fresher breath? Yes / No Whiter teeth? Yes / No

Do your gums bleed? Yes / No Do your gums itch? Yes / No

- Have you ever been told you have periodontal (bone) disease? Yes / No
- Do you have mobility in your teeth? Yes / No
- Are your teeth sensitive to heat, cold, or anything else?

  _____
- Do you still have wisdom teeth? Yes / No

  If yes, why? _____
- Previous Doctor: _____
- Date of last visit _____
- Why did you leave your last dentist?

  _____
- What did you like most / least about any dentist you have seen? _____
- Are you happy with the way your smile looks? Yes / No

  If not, what would you like to change? _____

Do you have a personal physician (family doctor)? Yes / No

Physician's Name: _____

Address: _____

Phone #:(____)_____Date of last visit:_____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes / No

Please explain: _____

Do you smoke or use tobacco in any form? Yes / No

Are you allergic to any of the following?

Y / N Aspirin	Y / N Latex
Y / N Barbiturates	Y / N Penicillin
Y / N Codeine	Y / N Sedatives
Y / N Dental Anesthetics	Y / N Sulfa Drugs
Y / N Erythromycin	Y / N Tetracycline
Y / N Jewelry/Metals	Y / N Other

Please list additional drugs/materials that cause allergic reactions: _____

Are you taking any of the following:

Y / N Acetaminophen	Y / N Digitalis/Heart Medication
Y / N Antibiotics	Y / N Insulin/Diabetes Drugs
Y / N Antihistamines	Y / N Nitroglycerin
Y / N Aspirin	Y / N Recreational Drugs
Y / N Blood Thinners	Y / N Steroids/Cortisone
Y / N Blood Pressure Medication	Y / N Thyroid Medicine
Y / N Cold Remedies	Y / N Tranquilizers

Have you ever taken Phen-Fen (Redux or Pondimin)? Yes / No

Are you currently taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above? Yes / No

If yes, please list each one _____

Do you need pre-medicated before dental work? Yes/No

WOMEN: Are you taking birth control pills? Yes / No

Are you pregnant? Unsure / Yes / No Week #: _____

Are you nursing? Yes / No

Have you ever had any of the following diseases or medical problems?

Y / N Abnormal Bleeding	Y / N Diabetes	Y / N Hemophilia	Y / N Persistent Cough	Y / N Tuberculosis
Y / N Alcohol Abuse	Y / N Difficulty Breath	Y / N Hepatitis	Y / N Psychiatric Problems	Y / N Ulcers
Y / N Anemia	Y / N Drug Abuse	Y / N Herpes	Y / N Radiation Treatment	Y / N Venereal
Y / N Arthritis	Y / N Emphysema	Y / N High Blood Pressure	Y / N Rheumatic Fever	Disease
Y / N Artificial Bones/Joints	Y / N Epilepsy	Y/ N HIV+/AIDS	Y / N Scarlet Fever	
Y / N Artificial Valves	Y / N Fainting Spells	Y / N Hospitalized for Any reason	Y / N Seizures	
Y / N Asthma	Y / N Fever Blisters	Y / N Kidney Problems	Y / N Shingles	
Y / N Blood Transfusion	Y / N Glaucoma	Y / N Liver Diseases	Y / N Sickle Cell Disease	
Y / N Cancer	Y / N Hay Fever	Y / N Low Blood Pressure	Y / N Sinus Problems	
Y / N Chemotherapy	Y / N Headaches	Y / N Lupus	Y / N Steroid Therapy	
Y / N Chicken Pox	Y / N Heart Attack	Y / N Mitral Valve Prolapse	Y / N Stroke	
Y / N Colitis	Y / N Heart Murmur	Y / N Osteoporosis	Y / N Thyroid Problems	CK'd By _____
Y/ N Congenital Heart Defect	Y / N Heart Surgery	Y / N Pacemaker	Y / N Tonsillitis	(office use)

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

My method of payment will be _____

_____ _____

SIGNATURE DATE

PAYMENT IS DUE AT TIME OF SERVICE

I certify that I am covered by _____ Insurance Co. and I assign directly to **Bruner Dental Center** all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ _____

SIGNATURE DATE

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.