BRITO FAMILY DENTAL

PATIENT LAST NAME: ______________________ **FIRST:** ______________ **INITIAL:** __________

How do you wish to be addressed? ______________________ Date of Birth __________

Address ______________________ City ______________ State __________ Zip __________

Telephone (Mobile) ______________________ (Work) ______________________ (Home) __________

Email ____

How did you hear about our practice? ____

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Subscriber Name ______________	Subscriber Name ______________
Subscriber ID ______________	Subscriber ID ______________
Date of Birth ______________	Date of Birth ______________
Relationship to Subscriber ☐Self ☐Spouse ☐Child ☐Other	Relationship to Subscriber ☐Self ☐Spouse ☐Child ☐Other
Employer Name ______________	Employer Name ______________
Employer Phone ______________	Employer Phone ______________
Insurance Company ______________	Insurance Company ______________
Insurance Group ______________	Insurance Group ______________
Insurance Phone ______________	Insurance Phone ______________

Please present your insurance card to be photocopied for our records.

RESPONSIBLE PARTY *(If minor)*

Last Name: ______________________ First: ______________ Initial: ______

Address *(If different)* ______________________ Date of Birth __________

City ______________________ State ______________ Zip __________

Telephone (Home) ______________________ (Work) ______________________ (Mobile) __________

Email ____

EMERGENCY CONTACT

Last Name: ______________________ First: ______________ Initial: ______

Telephone (☐ Mobile ☐ Work ☐ Home) ____

AUTHORIZATION

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

ELECTRONIC COMMUNICATIONS. I consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment and health care operations. I understand that there is no obligation to receive these electronic communications.

I attest to the accuracy of the information on this page.

Signature ____ Date ______________
(Responsible Party, if under 18)

PATIENT REGISTRATION

PLEASE COMPLETE ALL INFORMATION – THANK YOU

PATIENT LAST NAME: ______________________ **PATIENT FIRST NAME:** ______________________

DENTAL HISTORY

Reason for today's visit ______________________ Date of last dental visit ______________________

Former dentist ______________________ Date of last dental x-rays ______________________

Please check if you have/had:	Yes	No
Bad breath	☐	☐
Blisters on lips or mouth	☐	☐
Burning sensation on tongue	☐	☐
Chew on one side of mouth	☐	☐
Cigarette, pipe, or cigar smoking	☐	☐
Smokeless tobacco	☐	☐
Dry mouth	☐	☐
Food collection between teeth	☐	☐
Clench or grind teeth	☐	☐
Growths or sore spots in your mouth	☐	☐
Gums swollen, tender or bleeding	☐	☐

	Yes	No
Head, neck, jaw pain, or aches	☐	☐
Lip or cheek biting	☐	☐
Loose teeth or broken fillings	☐	☐
Mouth breathing	☐	☐
Orthodontic treatment	☐	☐
Nitrous Oxide	☐	☐
Periodontal treatment	☐	☐
Sensitivity to pressure or irritants (cold, heat, sweets)	☐	☐

How often do you floss? ______________

How often do you brush? ______________

Have you ever had an allergic reaction to Novocaine, local, or general anesthetics? ☐Yes ☐No

If Yes, please explain ______________________

Have you ever had trouble from previous dental care? ☐Yes ☐No If Yes, please explain ______________________

MEDICAL HISTORY

Physician's name ______________________ Date of last visit ______________________

Physician's address ______________________ ______________________Blood Pressure______________________

Have you had any serious illnesses or operations Yes ☐ No ☐ If yes, please describe ______________________

Have you ever had a blood transfusion Yes ☐ No ☐ If yes, give approximate dates ______________________

(Women) Are you pregnant? Yes☐ No ☐ Due date ______________ Nursing? Yes ☐ No ☐ Taking birth control pills? Yes ☐ No ☐

Please check if you have/had:	Yes	No
Allergies, hay fever, sinusitis	☐	☐
Anemia	☐	☐
Arthritis, Rheumatism	☐	☐
Artificial heart valves	☐	☐
Artificial joints	☐	☐
Asthma	☐	☐
Required Hospitalization	☐	☐
Have you used steroids	☐	☐
Date of last episode ______	☐	☐
Bleeding abnormally with operations or surgery	☐	☐
Blood disease, clotting disorders	☐	☐
Cancer	☐	☐
Chemical dependency	☐	☐
Chemotherapy	☐	☐
Circulatory problems	☐	☐
Cortisone treatments	☐	☐
Cough, persistent or bloody	☐	☐
Diabetes	☐	☐
Emphysema	☐	☐
Epilepsy	☐	☐
Fainting	☐	☐
Glaucoma	☐	☐

	Yes	No
Headaches	☐	☐
Heart murmur	☐	☐
Heart problems	☐	☐
Hepatitis type ___________	☐	☐
Herpes	☐	☐
High blood pressure	☐	☐
Any immune deficiency	☐	☐
Jaundice	☐	☐
Kidney disease	☐	☐
Low blood pressure	☐	☐
Mitral valve prolapse	☐	☐
Osteoporosis	☐	☐
Osteopenia	☐	☐
Pacemaker	☐	☐
Radiation treatments	☐	☐
Respiratory disease	☐	☐
Rheumatic fever	☐	☐
Scarlet fever	☐	☐
Shortness of breath	☐	☐
Sinus trouble	☐	☐
Sickle cell anemia	☐	☐
Skin rash	☐	☐

	Yes	No
Slow healing wounds	☐	☐
Stroke	☐	☐
Swelling of feet or ankles	☐	☐
Thyroid problems	☐	☐
Tonsilitis	☐	☐
Tuberculosis	☐	☐
Tumor or growth on head/neck	☐	☐
Ulcer	☐	☐
Venereal disease	☐	☐
Weight loss, unexplained	☐	☐
Do you wear contact lenses?	☐	☐
Do you consume alcoholic beverages?	☐	☐
Are you currently under the care of a Physician?	☐	☐
Are you allergic/sensitive to Latex?	☐	☐
Allergic to Penicillin, Aspirin, or other drugs?	☐	☐

If Yes, please specify ______________________

List any medications that you are taking:

____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature ______________________ Date ______________

Reviewed by: ______________________ Date ______________

DENTAL & MEDICAL HEALTH HISTORY