



Patient Information

Date _____ Social Security # _____ Birthdate _____

Name _____ Home Phone _____

Address _____ Cell Phone _____

City _____ State _____ Zip _____ E-mail _____

Sex: Male Female Minor Single Married Divorced Widowed

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

Primary Dental Insurance

Person Responsible for Account _____

Relationship to Patient _____ Birthdate _____ Soc. Sec # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____ Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Dental History

Former Dentist _____ Date of Last X-Rays? _____

City, State _____ How often do you floss? _____

Date of Last Dental Visit _____ How often Do You Brush? _____

Please check all that apply:

Bad Breath..... <input type="checkbox"/>	Loose Teeth or Broken Fillings..... <input type="checkbox"/>	Sensitive to Sweets..... <input type="checkbox"/>
Bleeding Gums..... <input type="checkbox"/>	Orthodontic Treatment <input type="checkbox"/>	Sensitivity When Biting..... <input type="checkbox"/>
Blisters on Lips or Mouth.... <input type="checkbox"/>	Pain Around Ear <input type="checkbox"/>	Frequent Headaches..... <input type="checkbox"/>
Finger Nail Biting..... <input type="checkbox"/>	Periodontal Treatment..... <input type="checkbox"/>	Jaw, Head or Neck Injuries... <input type="checkbox"/>
Grinding Teeth..... <input type="checkbox"/>	Sensitivity to Cold..... <input type="checkbox"/>	Jaw Difficulty: Clicking/Pain. <input type="checkbox"/>
Lip or Cheek Biting..... <input type="checkbox"/>	Sensitivity to Hot..... <input type="checkbox"/>	Tooth Pain..... <input type="checkbox"/>

Medical History

Physician's Name _____ Date of Last Visit _____

1. Are you currently under medical treatment? _____ 8. Have you had any allergic reactions to the following?

2. Have you ever had a serious illnesses/operations? _____

Local Anesthetics (Novocain) _____

3. Are you currently taking any medication? _____

Penicillin or other Antibiotics _____

If yes please describe: _____

Sulfa Drugs _____

4. Do you smoke? _____

Barbiturates (Sleeping Pills) _____

5. Do you use alcohol? _____

Sedatives _____

6. Do you use drugs? _____

Iodine _____

7. Do you wear contact lenses? _____

Aspirin _____

Other _____

9. (Women Only) Are You: Pregnant? _____ Nursing? _____ Taking birth control pills? _____

Please check all that apply:

Aids..... <input type="checkbox"/>	Back Problems..... <input type="checkbox"/>	Chemotherapy..... <input type="checkbox"/>
Emphysema..... <input type="checkbox"/>	Heart Problems..... <input type="checkbox"/>	Jaw Pain..... <input type="checkbox"/>
Pacemaker..... <input type="checkbox"/>	Shortness of Breath..... <input type="checkbox"/>	Thyroid Glands..... <input type="checkbox"/>
Anemia..... <input type="checkbox"/>	Bleeding Abnormally, With extractions or surgery..... <input type="checkbox"/>	Chronic Fatigue Syndrome..... <input type="checkbox"/>
Epilepsy..... <input type="checkbox"/>	Hepatitis-Type _____ <input type="checkbox"/>	Latex Sensitivity..... <input type="checkbox"/>
Psychiatric Care..... <input type="checkbox"/>	Sinus Trouble..... <input type="checkbox"/>	Tonsillitis..... <input type="checkbox"/>
Arthritis, Rheumatism..... <input type="checkbox"/>	Herpes..... <input type="checkbox"/>	Circulatory Problems..... <input type="checkbox"/>
Fainting/Dizziness..... <input type="checkbox"/>	Skin Rash..... <input type="checkbox"/>	Kidney Disease..... <input type="checkbox"/>
Radiation Treatment..... <input type="checkbox"/>	Blood Disease..... <input type="checkbox"/>	Tuberculosis..... <input type="checkbox"/>
Artificial Heart Valves..... <input type="checkbox"/>	High Blood Pressure..... <input type="checkbox"/>	Congenital Heart Lesions..... <input type="checkbox"/>
Glaucoma..... <input type="checkbox"/>	Stroke..... <input type="checkbox"/>	Liver Disease..... <input type="checkbox"/>
Respiratory Disease..... <input type="checkbox"/>	Cancer..... <input type="checkbox"/>	Tumor or growth on head/neck..... <input type="checkbox"/>
Artificial Joints..... <input type="checkbox"/>	HIV Positive..... <input type="checkbox"/>	Cortisone Treatments..... <input type="checkbox"/>
Headaches..... <input type="checkbox"/>	Swelling of Feet/Ankles..... <input type="checkbox"/>	Low Blood Pressure..... <input type="checkbox"/>
Rheumatic Fever..... <input type="checkbox"/>	Chemical Dependency..... <input type="checkbox"/>	Ulcer..... <input type="checkbox"/>
Asthma..... <input type="checkbox"/>	Jaundice..... <input type="checkbox"/>	Cough-persistent or bloody..... <input type="checkbox"/>
Heart Murmur..... <input type="checkbox"/>	Swollen Neck Glands..... <input type="checkbox"/>	Mitral Valve Prolapse..... <input type="checkbox"/>
Scarlet Fever..... <input type="checkbox"/>		Venereal Disease..... <input type="checkbox"/>
Nervous Problems..... <input type="checkbox"/>		Diabetes..... <input type="checkbox"/>

Assignment and Release

I hereby authorize payment directly to Branham Dental Arts for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____