MEDICAL HISTORY

(Since your overall health affects your dental health, we request the following information)

Physician's name and phone # _____

Date of your last complete physical examination _____

List ALL medications that you are currently taking including vitamins and aspirin:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have you ever been told that you need to pre-medicate with an antibiotic before any dental procedures?
Please circle YES or NO

Please circle any medications or products that you have had an allergic reaction to:

Aspirin Codeine Metals Sulfa
Cleocin Latex Penicillin Other _____

Do you have or have you ever had any of the following? Please check the appropriate box next to each category:

	YES	NO		YES	NO
AIDS	☐	☐	High Blood Pressure	☐	☐
Alzheimer's Disease	☐	☐	HIV Positive	☐	☐
Anemia	☐	☐	Irregular Heartbeat	☐	☐
Angina Chest Pain	☐	☐	Jaundice	☐	☐
Arthritis	☐	☐	Kidney Disease	☐	☐
Artificial Heart Valve	☐	☐	Liver Disease	☐	☐
Artificial Joint (Hip, Knee)	☐	☐	Lung Disease	☐	☐
Asthma	☐	☐	Mitral Valve Prolapse	☐	☐
Bleeding or bruising problems	☐	☐	Pacemaker	☐	☐
Blood Transfusion	☐	☐	Psychiatric Care	☐	☐
Bypass/Heart Surgery	☐	☐	Radiation for Cancer	☐	☐
Cancer	☐	☐	Rheumatic Fever	☐	☐
Chemotherapy	☐	☐	Sickle Cell Anemia	☐	☐
Chronic Cough	☐	☐	Sinus Problems	☐	☐
Cold Sores	☐	☐	Stroke	☐	☐
Contact Lenses	☐	☐	Thyroid Problems	☐	☐
Cortisone\Steroid Medication	☐	☐	Tuberculosis	☐	☐
Diabetes	☐	☐	Tumors	☐	☐
Dialysis	☐	☐	Ulcers	☐	☐
Emphysema	☐	☐	Venereal Disease	☐	☐
Epilepsy or Convulsions	☐	☐			
Fainting or Dizziness	☐	☐	**Family history of:** Heart Disease	☐	☐
Glaucoma	☐	☐	Diabetes	☐	☐
Gout	☐	☐	**Do you:** Use chewing tobacco	☐	☐
Heart Attack	☐	☐	Smoke	☐	☐
Heart Disease	☐	☐	Use recreational drugs	☐	☐
Heart Murmur	☐	☐	Drink soda pop	☐	☐
Hemophilia	☐	☐	**Women Only Please Check:**		
Hepatitis A	☐	☐	Pregnant ☐ Postmenopausal ☐		
Hepatitis B	☐	☐	Nursing ☐ Use Oral contraceptives ☐		

Is there any additional information that you would like us to have concerning your health?

_____

_____

_____

I agree that the information above is accurate and complete to the best of my knowledge.

Patient Signature _____ **Date:** _____

Patient Name _____

DENTAL HISTORY

Reason for your visit today _____
Date of last dental visit _____
Treatment received _____
Previous dentist _____
***Please contact your former dentist for a copy of your records and x-rays.**

Do You:	**Yes**	**No**
Think you have a cavity?	☐	☐
Think you have gum disease?	☐	☐

Have you received treatment for any of the following:	**Yes**	**No**
Orthodontics	☐	☐
Oral Surgery	☐	☐
Periodontal (gum) Treatment	☐	☐
TMJ Treatment/Bite Plate	☐	☐

Have you experienced any of the following:

	Yes	**No**		**Yes**	**No**
Sweet sensitivity	☐	☐	Grinding at night	☐	☐
Hot sensitivity	☐	☐	Clenching during the day	☐	☐
Cold sensitivity	☐	☐	Tired muscles or jaw	☐	☐
Biting or chewing pain	☐	☐	Clicking or noises of the jaw	☐	☐
Bleeding gums	☐	☐	Jaw pain	☐	☐
Frequent mouth sores	☐	☐	Trouble opening or closing	☐	☐
Injury to teeth or jaw	☐	☐	Other _____		

Have you experienced any of the following during or after dental treatments:

	Yes	**No**
Abnormal Bleeding	☐	☐
Fainting	☐	☐
Trouble reclining in a dental chair	☐	☐
Allergic reaction	☐	☐
Complications from nitrous oxide	☐	☐
Other complications	☐	☐

Would you like to change:	**Yes**	**No**
Appearance of your smile	☐	☐
Color of your teeth	☐	☐
Shape of your teeth	☐	☐
Position of your teeth	☐	☐

For your comfort, please check the following items you would like to use:

- Nitrous oxide ☐
- Television or music ☐
- Neck pillow ☐
- Bite prop ☐

Is there anything about going to the dentist that concerns you? _____

_____

_____

OVER-

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
Gender: _____ Family Status _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ Ext: _____ Best time to call: _____
(Cell) _____ (E-mail) _____
Address: _____
Street Apartment #
City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative
☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____
Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment
Name: _____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work) _____ Ext: _____ Best Time to call: _____
Address: _____
Street Apartment #
_____
City State Zip Code

Employment Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment
Employer Name: _____ Occupation: _____
Address _____
Street City State Zip Code Phone

Insurance Information

Primary
Name of Insured: _____ Is the insured a patient? ☐ Yes ☐ No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street City State Zip Code
Insured's Employer Name: _____
Address: _____
Street City State Zip Code
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Insurance Plan Name and Address: _____
_____

Secondary
Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI
Insured's Birth Date _____ ID #: _____ Group #: _____
Insured's Address: _____
Street City State Zip Code
Insured's Employer Name: _____
Address: _____
Street City State Zip Code
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 ½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefor the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waver of any breach of any condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fee if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date:_____ Relationship to Patient:_____

Signature of patient, parent or guardian

_____ Date:_____ Relationship to Patient:_____

Signature of guarantor of payment/responsible party

Burvant Family Dentistry

HIPAA Privacy Policy

I have received and reviewed a copy of our dental practice's privacy, security and breach notification policies and procedures.

I understand that I should ask our dental practice's Privacy Official if I have any questions about these policies and procedures.

Print name: _____

Signature: _____

Date: _____