WELCOME TO OUR PRACTICE- TELL US ABOUT YOURSELF

Name: ____ Today's Date: _____________

Date of Birth ___________ SS#:_________________ Male ☐ Female☐

Address:_____________________________City______________State_____ Zip_________

Cell#: ____________ Home#:___________ Work#:___________ **Preferred #: C ☐ W ☐ H ☐**

Email Address: ____

Is it ok for us to email or text you about your appointments? ☐ YES ☐ NO

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

Patient or Parent's Employer:___________________ Occupation:__________________

Spouse or Parent/Guardian's Name:_______________ Employer: ___________________

How Did You Hear About Our Office? ____

How Can We Help You Today? ____

Insurance Information – Primary **I DO NOT HAVE DENTAL INSURANCE** ☐

Subscriber Name: __________________________ Relationship to Patient:____________ Subscriber DOB: __________ Subscriber SSN#/ID:_________________ Insurance Company Name:____________________ Subscriber Employer:________________ Insurance Phone #:_______________ Group#:__________ Policy/ID#:_____________

Here, Dr. Briese offers a wide variety of services to enhance and keep your smile beautiful. Please check any services below that interest you:

☐ Tooth Whitening	☐ Dental Implants	☐ Invisalign or Braces
☐ Sedation Dentistry	☐ Veneers	☐ Smile Makeover
☐ Sealants	☐ Crowns / Bridges	☐ Partial/Complete Dentures
☐ Wisdom Teeth Removal	☐ Night/Sports Guards	☐ Gum Treatment/Cleanings
☐ Fluoride Treatment	☐ Bonding	☐ Tooth Grinding Treatment

Assignment and Release:

I, the undersigned, certify that I (or my dependent) have read and understood the information above and have provided accurate information to the questions provided. I hereby authorize the dentist to release any information including the diagnosis and the records of any treatment rendered to me or my child to 3rd party payors and/or health care professionals. I also understand that I am financially responsible for all charges whether or not paid by insurance. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient/Guardian:______________________________Today's Date:___________

MEDICAL HISTORY

Do you have a personal physician? ☐ YES ☐ NO Physician's Name: ___________________

Is he/she a medical specialist (i.e cardiologist,etc)? ☐ YES ☐ NO What Type ___________

Date of Last Visit: __________________________

What type of medical condition are you being treated for?

Please explain: ____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Have you had any surgical procedures? ☐ YES ☐ NO Please explain__________________________

Do you take any medications? ☐ YES ☐ NO

Please list medications: ____

Do you use tobacco? YES: ☐ Cigarettes ☐ Cigar ☐ Smokeless (dip) **NO** ☐

Have you ever taken Fosomax, Boniva, Actonel, Reclast or any other medications containing ***bisphosphonates***? ☐ YES ☐ NO

Yes	No	Conditions	Yes	No	Conditions	Yes	No	Conditions
☐	☐	Abnormal Bleeding	☐	☐	Glaucoma	☐	☐	Stroke
☐	☐	Alcohol Abuse	☐	☐	HIV-AIDS	☐	☐	Thyroid Problem
☐	☐	Allergies	☐	☐	Heart Attack	☐	☐	Tuberculosis
☐	☐	Anemia	☐	☐	Heart Murmur	☐	☐	Ulcers
☐	☐	Angina Pectoris	☐	☐	Heart Surgery			
☐	☐	Arthritis	☐	☐	Hemophilia			
☐	☐	Artificial Heart Valve	☐	☐	Hepatitis			
☐	☐	Asthma	☐	☐	High Blood Pressure			
☐	☐	Blood Transfusion	☐	☐	Joint Replacement			
☐	☐	Cancer	☐	☐	Kidney problems			
☐	☐	Chemotherapy	☐	☐	Liver Disease			
☐	☐	Colitis	☐	☐	Low Blood Pressure			
☐	☐	Congenital Heart Defect	☐	☐	Mitral Valve Prolapse			
☐	☐	Diabetes	☐	☐	Pacemaker			
☐	☐	Difficulty Breathing	☐	☐	Psychiatric Problems			
☐	☐	Drug Abuse	☐	☐	Radiation Therapy			
☐	☐	Emphysema	☐	☐	Rheumatic Fever			
☐	☐	Epilepsy	☐	☐	Seizures			
☐	☐	Facial Surgery	☐	☐	STD's			
☐	☐	Fainting Spells	☐	☐	Shingles			
☐	☐	Fever Blisters	☐	☐	Sickle Cell Disease			
☐	☐	Frequent Headaches	☐	☐	Sinus Problems			

Yes	No	***ALLERGIES***
☐	☐	Local anesthetic (i.e Lidocaine)
☐	☐	Epinephrine
☐	☐	Penicillin/Amoxicillin
☐	☐	Clindamycin
☐	☐	Corticosteroids (i.e Decadron, Prednisone)
☐	☐	Sulfa Drugs
☐	☐	Pain Medicine (hydrocodone, codeine, etc)
☐	☐	Aspirin
☐	☐	LATEX RUBBER
☐	☐	Any metals (i.e Nickel, Mercury, etc)
☐	☐	OTHER: please explain _________________

YES	NO	***IF FEMALE, PLEASE ANSWER***
☐	☐	Are you taking birth control?
☐	☐	Are you pregnant? If so, how many weeks? _________
☐	☐	Are you nursing?

Nearest relative not living with you:

Name: ____________________ Relationship:______________ Phone#:_____________________

I understand the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of ANY CHANGES TO MY MEDICAL STATUS at future dental appointments.

Signature:____ Today's Date: ________