



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? _____

Here, Dr. Briese can take care of your basic dental needs but we can also provide more premium and elective services. Please check any services below that interest you:

- | | | |
|--|---|--|
| <input type="checkbox"/> Dental Implants | <input type="checkbox"/> Teeth Whitening | <input type="checkbox"/> Invisalign or Braces |
| <input type="checkbox"/> Sedation Dentistry | <input type="checkbox"/> Porcelain Veneers | <input type="checkbox"/> Smile Makeover |
| <input type="checkbox"/> Wisdom Teeth Removal | <input type="checkbox"/> Smile Transformations | <input type="checkbox"/> Partial/Complete Dentures |
| <input type="checkbox"/> Sleep Apnea Treatment | <input type="checkbox"/> Night/Sports Guards | <input type="checkbox"/> Gum Treatment/Cleanings |
| <input type="checkbox"/> Bonding | <input type="checkbox"/> Tooth Grinding Treatment | |

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#: _____

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.

MEDICAL HISTORY

- Do you have a personal physician? YES NO
- Physician's Name: _____
- Do you also see a medical specialist? (i.e cardiologist,etc) YES NO
List type of Specialist and their name/location: _____

- List the current medications you take:

- Do you take blood thinner medications YES NO
- Circle which blood thinner: Eliquis, Plavix, Pradaxa, Coumadin, Xarelto, Aspirin
or list other: _____

- Have you been hospitalized for any medical procedures? YES NO
- Please list when and what type of surgery was done: _____

- Have you ever had any problems with being sedated for surgery? YES NO
Please list issue with sedation: _____

- Do you take any GLP Medications (Ozempic, Monjurno, Adipex, PhenPhen) YES NO

- Do you take medications for osteoporosis? YES NO
When did you start taking the medication? What was the date? _____
How often do you take the medication? _____
Which medication do you or did you take for osteoporosis? Circle One
Prolia, Fosamax, Boniva, Actonel, Reclast, Evista, Evenity
or list other name: _____

- Do you use smoke? YES: Cigarettes Cigar Cannabis **NO**
-
- Do you use smokeless tobacco (dip)? YES NO
-
- Do you use Nicotine pouches? YES NO

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: _____

Yes No Conditions

- Abnormal Bleeding
- Anemia
- Angina Pectoris
- Artificial Heart Valve
- Asthma

- Blood Transfusion
- Cancer
- Chemotherapy
- Colitis
- Congenital Heart Defect
- COPD
- Diabetes
- Difficulty Breathing
- Drug Abuse
- Emphysema
- Epilepsy
- Facial Surgery
- Fever Blisters
- HIV-AIDS

Yes No Conditions

- Heart Attack
- Stroke
- Heart Surgery
- Heart Bypass
- Heart Stents

- Hepatitis
- High Blood Pressure
- Joint Replacement
- Kidney problems
- Liver Disease

- Low Blood Pressure
- Pacemaker
- Psychiatric Problems
- Radiation Therapy
- Rheumatic Fever
- Seizures
- Shingles
- 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?

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Signature: _____

Today's Date: _____