PATRICK BRIESE
DENTISTRY
GENERAL DENTISTRY IMPLANT DENTISTRY

## 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? _____

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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:

☐ Dental Implants
☐ Sedation Dentistry
☐ Wisdom Teeth Removal
☐ Sleep Apnea Treatment
☐ Bonding
☐ Teeth Whitening
☐ Porcelain Veneers
☐ Smile Transformations
☐ Night/Sports Guards
☐ Tooth Grinding Treatment
☐ Invisalign or Braces
☐ Smile Makeover
☐ Partial/Complete Dentures
☐ Gum Treatment/Cleanings

**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.

Signature of Patient/Guardian:_____Today's Date:_____

## 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 have any prosthetic joints or prosthetic valves in your body? ☐ YES NO ☐
- Do you require ANTI-BIOTIC PROPHYLASXIS before dental procedures? ☐ YES NO ☐

- Do you take any GLP Medications or weight loss drugs: (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 tobacoo (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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