BROOKSIDE DENTAL

WELCOME

The benefits of a happy, healthy smile are immeasurable!
Our goal is to help you reach and maintain maximum oral health.
Please fill out this form completely.
The better we communicate, the better we can care for you.

ABOUT YOU

Name _____

Preferred name _____

☐Male ☐Female ☐Single ☐Married ☐Widowed ☐Separated ☐Partner

Birthdate _____ Age _____ SS# _____

Address _____

City _____ State _____ Zip _____

Home # _____ Mobile# _____

Email _____ Fax# _____

Employer _____ Work# _____

Whom may we thank for referring you? _____

Other family members seen by us? _____

SPOUSE INFORMATION

Name _____ Birthdate _____

Work# _____ Mobile# _____

Birthdate _____ Email _____

CHILDREN INFORMATION

Name _____ Birthdate _____

Name _____ Birthdate _____

Name _____ Birthdate _____

Name _____ Birthdate _____

INSURANCE

Provider Name _____

Provider Address _____

City _____ State ____ Zip _____

Phone# _____

Group# _____

ID# _____

Insurer's Name _____

Relationship _____

Insured's Birthdate _____

Insured's Employer _____

Insured's Phone# _____

Insured's SSI# _____

IF YOU HAVE SECONDARY INSURANCE PLEASE LET A TEAM MEMBER KNOW

ACCOUNT INFO

PERSON RESPONSIBLE FOR ACCOUNT

Name _____ Relationship _____ Birthdate _____

Home# _____ Work# _____ Mobile# _____

Email _____

Billing Address _____

City _____ State _____ Zip _____

SSI# _____

MEDICAL HISTORY

Do you have a Physician? ☐Yes ☐No

Physician's Name _____

Phone# _____ Last visit date _____

Are you currently under the care of a physician? ☐Yes ☐No

Please explain _____

Your current physical ☐Good ☐Fair ☐Poor

Do you smoke or use tobacco in ant form? ☐Yes ☐No

Are you taking any prescription/over the counter drugs? ☐Yes ☐No

If so, please list each one _____

Are you taking any medications for Osteoporosis? oYes oNo

If so, please list each one

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Aspirin	☐Yes	☐No	Jewelry/Metals	☐Yes	☐No
Codeine	☐Yes	☐No	Latex	☐Yes	☐No
Dental Anesthetics	☐Yes	☐No	Penicillin	☐Yes	☐No
Erythromycin	☐Yes	☐No	Tetracycline	☐Yes	☐No
Other	☐Yes	☐No			

Please list any other drugs/materials that you are allergic to:

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Abnormal Bleeding	☐Yes	☐No	High blood pressure	☐Yes	☐No
Alcohol/Drug abuse	☐Yes	☐No	HIV/AIDS	☐Yes	☐No
Anemia	☐Yes	☐No	Hospitalized for any reason	☐Yes	☐No
Artificial Bones,Joints or Valves	☐Yes	☐No	Kidney Problems	☐Yes	☐No
Asthma	☐Yes	☐No	Liver Disease	☐Yes	☐No
Blood Transfusion	☐Yes	☐No	Low Blood Pressure	☐Yes	☐No
Cancer/Chemotherapy	☐Yes	☐No	Lupus	☐Yes	☐No
Colitis	☐Yes	☐No	Mitral Valve Prolapse	☐Yes	☐No
Congenital Heart defect	☐Yes	☐No	Pacemaker	☐Yes	☐No
Diabetes	☐Yes	☐No	Psychiatric Problems	☐Yes	☐No
Difficulty Breathing	☐Yes	☐No	Radiation Treatment	☐Yes	☐No
Emphysema	☐Yes	☐No	Rheumatic/Scarlet fever	☐Yes	☐No
Epilepsy	☐Yes	☐No	Seizures	☐Yes	☐No
Fainting Spells	☐Yes	☐No	Shingles	☐Yes	☐No
Frequent Headaches	☐Yes	☐No	Sickle Cell Disease	☐Yes	☐No
Glaucoma	☐Yes	☐No	Sinus Problems	☐Yes	☐No
Hay Fever	☐Yes	☐No	Stroke	☐Yes	☐No
Heart Attack	☐Yes	☐No	Thyroid problems	☐Yes	☐No
Heart Surgery	☐Yes	☐No	Tuberculosis (TB)	☐Yes	☐No
Hemophilia	☐Yes	☐No	Ulcers	☐Yes	☐No
Hepatitis	☐Yes	☐No	Venereal Disease	☐Yes	☐No
Herpes/fever blisters	☐Yes	☐No			

Please list any medical condition(s) that you have ever had _____

over

FOR WOMEN ONLY

Are you taking any birth control pills? ☐Yes ☐No
Are you pregnant? ☐Yes ☐No
Are you nursing? ☐Yes ☐No

DENTAL HISTORY

Who was your previous dentist? _____
Practice Name _____
City _____ State _____
Phone# _____

Why did you leave your previous dentist? _____
_____
_____
_____

Why have you come to the dentist today? _____
_____
_____
_____

Has your doctor told you that you require antibiotics before dental treatment? ☐Yes ☐No
Are you currently in pain? ☐Yes ☐No
Have you ever had a serious/difficult problem associated with any previous dental work? ☐Yes ☐No
Do you or have you ever experienced pain/discomfort in your jaw joint? (TMJ/TMD) ☐Yes ☐No
Your current dental health is ☐Good ☐Fair ☐Poor
Do you like your smile? ☐Yes ☐No
Do your gums ever bleed? ☐Yes ☐No
How many times a week do you floss? _____
How many times a day do you brush? _____
Type of toothbrush bristles? ☐Hard ☐Medium ☐Soft
Sensitivity to heat and cold? ☐Yes ☐No If so, which teeth
_____

Headaches, earaches, neck pain? ☐Yes ☐No
Teeth or fillings breaking? ☐Yes ☐No
Grinding or clenching teeth? ☐Yes ☐No
Bleeding, swollen or irritated gums? ☐Yes ☐No
Loose, ripped, or shifting teeth? ☐Yes ☐No
Bad breath? ☐Yes ☐No
Do you consume alcohol? ☐Yes _____ per week ☐No
Please share the following approximate dates:
Your last cleaning _____
Last oral cancer screening _____
Last complete X-rays _____

On a 1 to 5 scale, 5 being the highest rating:
(Please circle the number that applies best}

How important is your dental health to you?
1 2 3 4 5

How would you rate your current dental health?
1 2 3 4 5

Where do you want your dental health to be?
1 2 3 4 5

DENTAL WISHES

If you could change something about your smile, would you
(please check all that apply}

- ☐ Make my teeth whiter
- ☐ Make my teeth straighter
- ☐ Close spaces between my teeth
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

FINANCIAL POLICY

Dental treatment is an excellent investment in an individual's well being, both medical and psychological. Financial considerations should not be an obstacle to obtaining this important health service. We are happy to file your dental insurance claims for you. **Payment is due in full at the time of service unless proper arrangements have been made in advance.** Being sensitive to the different needs of our patients, we are providing the following payment options: cash, credit card, financing or prepayment plans. Patients will be responsible for any interest accrued after 60 days.

APPOINTMENT POLICY

To respect both our patient's time and ours, we do have a $40 for 1 hour, $75 for 2 hour , 48 hour notice cancellation policy.

DISCLAIMER

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental team to perform any necessary dental services that I need during diagnosis and treatment with my informed consent.

In the event that payment in full for charges incurred are not made, I agree to pay off all costs of collection including a 50% collection fee, attorney fees and court costs.

Signature _____ Date _____

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the , and the ADA.

BROOKSIDE
DENTAL