

Ben H. Britt, Jr., DDS, PA

Confidential Patient Information

PATIENT

Name _____ Male Female
Last First Middle Preferred

Address _____
City State Zip

Home Phone _____ Cell Phone _____ Email _____

Do we have your permission to contact you via email or text message with appointment reminders and other office information? Email: Yes No Text: Yes No

Date of Birth ____/____/____ SSN ____-____-____ Marital Status: Single Married

Emergency Contact _____
Name Phone Number Relationship

Has any member of your family previously been treated in our office? Yes No

If so, what is their name and relationship to you? _____

Place of Employment _____ Occupation _____

Business Address _____ Business Phone _____
City State

PERSON RESPONSIBLE FOR ACCOUNT Same as above

Name _____ Date of Birth ____/____/____ SSN ____-____-____

Place of Employment _____ Occupation _____

Business Address _____ Business Phone _____
City State

DENTAL INSURANCE

PRIMARY Insurance Carrier _____ Phone Number _____

Mailing Address _____ Group Number _____

Subscriber's Name _____ ID/SS Number _____ Date of Birth ____/____/____

MEDICAL HISTORY

Physician's Name _____ Phone Number _____

Date of last complete physical: _____ Are you under a doctor's care now? Yes No

Please describe any current medical conditions: _____

Please list any medications (with dosages) or vitamins you are currently taking: _____

Are you pregnant or nursing? Yes No If you are pregnant, when is your due date? _____

Are you allergic to any of the following? Penicillin Codeine Local Anesthetics Latex

Shellfish/Seafood Other drugs/materials allergic to: _____

Have you ever been diagnosed with a heart murmur? Yes No If yes, do you require premedication? Yes No

Have you received a prosthetic joint in the last 2 years? Yes No

Are you subject to prolonged bleeding? Yes No

Do you smoke or use tobacco? Yes No Frequency: _____

Please CHECK if you have or have had any of the following:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Swelling of | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid/Parathyroid |
| <input type="checkbox"/> Low Blood Pressure | Feet/Ankles/Hands | <input type="checkbox"/> Hepatitis A (infectious) | Disease |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hepatitis B (serum) | <input type="checkbox"/> Arthritis/Gout |
| <input type="checkbox"/> Congenital Heart Lesion | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Acid Reflux |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Fever Blisters/Herpes | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Sinus Infections | <input type="checkbox"/> Cancer | <input type="checkbox"/> Drug/Alcohol Abuse |
| <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Chemotherapy/Radiation | <input type="checkbox"/> Psychiatric Care |

Please describe any serious illness you have had not listed above: _____

DENTAL HEALTH

Why have you chosen our dental practice? _____

What is your reason for today's visit? _____

Previous Dentist _____ Phone Number _____

Date of last visit: _____ Do you have dental records that need to be transferred to our office? Yes No

How important is it for you to keep your teeth for the rest of your life? Very Somewhat Not important

Have you ever had complications following dental treatment? _____

Have you ever received orthodontic treatment? Yes No Periodontal treatment? Yes No

Are you concerned about any of the following? Discolored teeth Discolored fillings

Space between teeth Broken or chipped teeth Missing teeth Crowding or crooked teeth

Loose Teeth Joint/Jaw Pain Other _____

Are you interested in whitening your teeth for a brighter smile? Yes No

If there is anything you could change about your smile, what would it be? _____

**To the best of my knowledge, all of the preceding information is true and correct.
If I ever have a change in my health, I will inform the office at my next dental appointment without fail.**

Patient or Guardian's Signature

Date