BRITT DENTAL CENTER
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 _____-_____-_____

Emergency Contact _____
Name Phone Number Relationship

Place of Employment _____Occupation _____

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

If so, what is his/her name and relationship to you? _____

Do you have dental insurance? □ Yes □ No If yes, please provide us a copy of your most recent insurance card.

Are you interested in more information on our Britt Dental Care discount savings plan for you or your family as an alternative to dental insurance? □ Yes □ No

PERSON RESPONSIBLE FOR ACCOUNT □ Same as above

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

Place of Employment _____Occupation _____

Business Address _____ Business Phone _____
City State

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? □ Yes □ No If you are pregnant, when is your due date? _____

Are you currently nursing? □ Yes □ No (continued on reverse)

Are you allergic to any of the following? □ Penicillin □ Latex □ Other: _____

Do you have a history of endocarditis? □ Yes □ No

Have you received a prosthetic joint in the last 6 months? □ Yes □ No

Are you subject to prolonged bleeding? □ Yes □ No

Do you smoke or use tobacco in any form? □ Yes □ No Frequency: _____ Type: _____

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

□ High Blood Pressure	□ Fainting or Dizziness	□ Liver Disease	□ Thyroid/Parathyroid Disease
□ Low Blood Pressure	□ Swelling of Feet/Ankles/Hands	□ Hepatitis A (infectious)	□ Arthritis/Gout
□ Rheumatic Fever	□ Stroke	□ Hepatitis B (serum)	□ Epilepsy or Seizures
□ Congenital Heart Lesion	□ Diabetes	□ Hepatitis C	□ Acid Reflux
□ Artificial Heart Valve	□ Tuberculosis	□ HIV Positive	□ Hypoglycemia
□ Heart Murmur	□ Kidney Trouble	□ Fever Blisters/Herpes	□ Drug/Alcohol Abuse
□ Shielded Pacemaker	□ Lung Disease	□ Cancer	□ Psychiatric Care
□ Unshielded Pacemaker	□ Sleep Apnea	□ Chemotherapy/ Radiation	
□ Mitral Valve Prolapse			

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 _____Date of last visit: _____Need records transferred? □ 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

□ Spaces between teeth □ Broken or chipped teeth □ Missing teeth □ Crowding or crooked teeth

□ Loose teeth □ Joint/Jaw pain □ Other _____

Have you been told that you grind your teeth? □ Yes □ No Have you been told that you snore? □ Yes □ No

Do you have any other concerns not mentioned above? _____

_____

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