Personal Information Form

Date: _____ Patient's First Name: _____ Last Name: _____ Nickname: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Sex: ☐ M ☐ F Age: _____ Birth Date:____/____/____ ☐ Single☐ Married ☐ Widow ☐ Separated ☐Divorced SS#: _____

Home Phone:_____ Work Phone:_____ Cell Phone: _____ Email Address: _____

Employer:_____ Occupation: _____

If Student, name of School/College: ☐ PT ☐ FT _____ City: _____ State:_____ Zip:_____

How did you first hear about our office: _____

Do we have your permission to send you occasional correspondence on informative dental topics as well as reminders of your appointments via email or text through our automated system? You may opt out at any time. ☐ Yes ☐ No

If the person responsible for this payment is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to the section entitled "Insurance Information".

Name of Responsible Party: _____ Relationship to Patient: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Sex: ☐ M ☐ F Age: _____ Birth Date:____/____/_____ ☐ Single ☐ Married ☐ Widow ☐ Separated ☐ Divorced SS#: _____

Home Phone:_____ Work Phone:_____ Cell Phone: _____ Email Address: _____

Employer:_____ Occupation: _____

Insurance Information

Policy Holder's Name: _____ Relationship to Patient: _____ SS#:_____ DOB:____/___/____

Name of Employer: _____ Employer Address: _____

Insurance Co.: _____ Group #: _____ Address: _____

Secondary Insurance Information

Policy Holder's Name: _____ Relationship to Patient: _____ SS#:_____ DOB:____/___/____

Name of Employer: _____ Employer Address: _____

Insurance Co.: _____ Group #: _____ Address: _____

Family Member Information

Please list the names of your spouse and children	Is person a patient Yes | No	Sex M | F	Age	Date of Birth (mm/dd/yyyy)
	☐ ☐	☐ ☐		
	☐ ☐	☐ ☐		
	☐ ☐	☐ ☐		

Please list the names of your spouse and children	Is person a patient Yes | No	Sex M | F	Age	Date of Birth (mm/dd/yyyy)
	☐ ☐	☐ ☐		
	☐ ☐	☐ ☐		
	☐ ☐	☐ ☐		

I certify that all of the information (including medical health history, personal, and insurance records) is true and complete. I understand that Brunswick Smiles will assist me in filing my claims, but the insurance coverage I have for dental services can vary and will depend on my insurance plan. I understand that I am responsible for all fees and services. Since our doctors often provide continuing education to other doctors, I give my permission to use my photos for educational purposes. I have read and agree to your HIPAA Notice of Privacy Practices.
If the patient is a minor, as the responsible party I give permission, in my absence, to provide examinations, dental cleanings and necessary x-rays as part of routine care for this patient.

Signature of Patient *(Responsible Party if a minor):* _____

Medical and Dental Health History Form

Patient's Name: _____

Medical Doctor's Name: _____Doctor's Phone #:_____Date of last completed physical: _____

Doctor's Address: _____City:_____State:_____Zip:_____

Are you taking <u>any</u> medication, vitamins or supplements? ☐ Yes ☐ No

If yes, please list: _____

For what purpose? _____

Rate your medical health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you pregnant? ☐ Yes ☐ No If yes, how many months: _____

Are you allergic or react to: ☐ Penicillin ☐ Codeine ☐ Local injected Anesthetic ☐ Latex ☐ Other _____

Have you ever been told that because of this you need to take antibiotics prior to dental cleanings or other treatment? ☐ Yes ☐ No

Do you have or have you <u>ever</u> had any of the following:

Abnormal Bleeding ☐ Yes ☐ No
AIDS or HIV Infection ☐ Yes ☐ No
Anemia ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No
Cancer/Chemotherapy/Radiation ☐ Yes ☐ No
Cardiovascular Disease ☐ Yes ☐ No
If yes please specify: _____
Heart Attack ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No

Eating Disorder ☐ Yes ☐ No
Epilepsy ☐ Yes ☐ No
Fainting spells or seizures ☐ Yes ☐ No
Gastrointestinal Disease ☐ Yes ☐ No
Glaucoma ☐ Yes ☐ No
Hemophilia ☐ Yes ☐ No
Mental Health Disorders ☐ Yes ☐ No
If yes please specify: _____
Osteoporosis ☐ Yes ☐ No
Respiratory Problems ☐ Yes ☐ No

Severe Headache/Migraines ☐ Yes ☐ No
Rapid Weight Loss/Gain ☐ Yes ☐ No
Sexually Transmitted Disease ☐ Yes ☐ No
Sinus Trouble ☐ Yes ☐ No
Sleep Disorder ☐ Yes ☐ No
Sore or Ulcers in Mouth ☐ Yes ☐ No
Stroke ☐ Yes ☐ No
Lupus ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No
Thyroid Problems☐ Yes ☐ No
Ulcers ☐ Yes ☐ No

** Do you have any disease, condition, or problem not listed above that your think we should know about?

Please Explain:_____

Do you ever get: ☐ Stress headaches ☐ Migraines ☐ Ear pain ☐ T M Joint pain ☐ Sensitive teeth ☐ Clicking in Jaw Joints ☐ Hard to chew or pain with chewing

General Dental Health and Concerns

What's most important to you about your teeth? _____
How would you rate your dental health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
What is the main barrier to your dental health being better? ☐ Fear ☐ Time ☐ Costs ☐ Other _____
Is keeping your teeth important to you? ☐ Yes ☐ No If yes, why? _____
Does having dental work make you feel anxious, nervous, or fearful? ☐ Yes ☐ No
How can we help you with any issues? _____
Do you have any: ☐ Discomfort in teeth or mouth ☐ Bleeding gums ☐ Bad breath ☐ Food traps around teeth

Dental Appearance

How would you rate the appearance of your smile from 1-10? _____

If you could make any changes about your dental appearance what would be important to you:

☐ Whiten Teeth
☐ Create a more youthful looking smile
☐ Replacing missing teeth
☐ Close spaces between teeth
☐ Cosmetic Veneers
☐ Replace discolored or old looking crowns
☐ Repair worn, chipped or broken teeth
☐ Remove silver fillings for health reasons
☐ Straighten teeth with braces or Invisalign