W. Christopher Bryant D.D.S. P.C.

NEW PATIENTS-PLEASE COMPLETE THE FOLLOWING

Thank you for coming to our office. It would be helpful to know how you heard about us. Please check the sources that apply.

❑Yellow Pages ❑Friend ❑Family Member ❑Coworker ❑Advertisement

Name of Person who referred you:_____

PATIENT INFORMATION

Please complete all the requested information.

PATIENTS NAME_____ DATE OF BIRTH_____

PATIENTS ADDRESS_____ PHONE #_____

CITY AND STATE_____ ZIP CODE_____

SINGLE___ MARRIED___ WIDOWED___ DIVORCED___

PERSON RESPONSIBLE FOR PATIENT'S EXPENSE

NAME_____ DATE OF BIRTH_____ RELATIONSHIP_____

ADDRESS_____ PHONE#_____

CITY AND STATE_____ ZIP CODE_____ SS#_____

EMPLOYER'S NAME_____ PHONE#_____

EMPLOYER'S ADDRESS_____ LENGTH OF EMPLOYMENT_____

INSURANCE INFORMATION

PRIMARY INSURANCE SUBSCRIBER_____ SOCIAL SECURITY #_____

GROUP#_____ HOURLY___ SALARY___ DATE OF BIRTH_____

EMPLOYER NAME_____ PHONE#_____

SECONDARY INSURANCE SUBSCRIBER_____ SOCIAL SECURITY#_____

GROUP#_____ HOURLY___ SALARY___ DATE OF BIRTH_____

EMPLOYER NAME_____ PHONE#_____

WHAT IS THE REASON FOR THIS VISIT? _____

WHEN WAS YOUR LAST DENTAL VISIT? _____

HAVE YOU EVER HAD FULL MOUTH X-RAYS? _____

Who is your personal physician? _____ Doctor's office location _____

Date of last complete physical exam? _____ Doctor's phone number _____

Please check "YES" or "NO"	YES	NO
Are you in good health?		
Are you currently under medical care?		
(If so, for what?)		
Do you take any medications regularly?		
(If so, what are they?)		
Do you need to take an Antibiotic before dental procedures are started?		

Please check "YES" or "NO"	YES	NO
Are you aware of any changes in your health in the past year?		
Comment:		
Have you ever been hospitalized?		
(If so for what?)		
Have you ever fainted in the dental office?		

Do you have or have you ever been treated for any of the following:

	YES	NO		YES	NO		YES	NO		YES	NO
Heart Disease/Attack	☐	☐	Mitral Valve Prolapse	☐	☐	Epilepsy	☐	☐	Any liver problems	☐	☐
Angina Pectoris	☐	☐	Heart Murmur	☐	☐	Arthritis	☐	☐	Excessive bleeding	☐	☐
Coronary Surgery	☐	☐	Congenital Heart Lesion	☐	☐	Asthma	☐	☐	Do you smoke	☐	☐
Artificial Heart Valve	☐	☐	Anemia	☐	☐	Emphysema	☐	☐	a. How much a day		
Heart Pacemaker	☐	☐	Diabetes	☐	☐	Hay Fever/Allergies	☐	☐	Do you chew tobacco	☐	☐
High Blood Pressure	☐	☐	Hepatitis B (Serum)	☐	☐	Bleeding Disorder	☐	☐	Prolonged bleeding	☐	☐
Low Blood Pressure	☐	☐	Hepatitis A (Infectious)	☐	☐	Venereal Disease	☐	☐			
Arteriosclerosis	☐	☐	Jaundice	☐	☐	HIV Positive (AIDS)	☐	☐			
Stroke	☐	☐	Kidney Disease	☐	☐	I am on dialysis	☐	☐			
Rheumatic Fever	☐	☐	Tuberculosis	☐	☐	Radiation treatment	☐	☐			

Have you ever experienced a rash, itching, or other reaction after use of any of these medications?

	YES	NO		YES	NO
Aspirin			Penicillin		
Local Anesthetics			Erythromycin		
Codeine			Tetracycline		
Sedatives			Other Antibiotics		
Iodine			Sulfa		

Is there any other mecical condition about you which we should know? Your medical health may affect our dental treatment. _____

_____

_____

_____

Do you have, or have you experienced	YES	NO
A. Shortness of breath on mild exertion		
B. Chest pain after/during exertions		
C. Swollen ankles		
D. Emotional problems, stress, or tension which cause you concern		
E. A tumor or abnormal growth		
F. Have you ever had counseling for stress, family problems, etc.		
G. Do you have dry mouth		
H. Have you had any serious trouble at any previous dental visits		
I. Are you wearing contact lenses		
J. Any artificial replacements and/or implants		
K. Allergy to latex		
LADIES		
1. Are you pregnant		
2. Do you take birth control pills		
3. Do you take estrogens or hormones		

I authorize the release of any dental information necessary to process an insurance claim. I authorize payment of dental benefits to the named provided for professional services rendered. I also understand that when my dental insurance coverage excludes or does not fully cover professional services rendered, I am responsible for the account balance in full.

Date _____ Patient's (Parents) Signature _____ Doctor's Signature _____

REVIEW DATE	CHANGES IN HEALTH STATUS	PATIENT'S SIGNATURE	DR.'S INITIALS	VITAL SIGNS
				P
				P
				P
				P
				P