



PATIENT INFORMATION FORM

About You

Last Name _____ First _____ Middle Initial _____

Name of Guardian if patient is a minor: _____

Circle one: Dr. Mr. Mrs. Ms. I prefer to be called: _____

Status: single married child other Gender: male female

Birth Date: ____/____/____ SS#: _____ - _____ - _____ DL# _____

Address: _____

City/State/Zip _____

Email Address: _____@_____

Home Telephone # _____ Work # _____ ext. _____

Fax #: _____ Pager #: _____ Cell #: _____

Employer: _____ Position/Title _____ # of yrs _____

Business Address: _____

Spouse's Name _____ Work #: _____ ext: _____

Other family members seen by us:(name/ relation) _____

Whom may we thank for referring you: _____

In case of Emergency contact: _____ Relation: _____ #: _____

Dental History

Name of Previous Dentist: _____ Phone# _____

Date of last dental visit: _____ Date of last cleaning: _____ Date of last X-Ray _____

Have you worn braces? no yes If yes, Date removed: _____ Orthodontist's Name: _____

Are you currently wearing your retainer every night: Yes No, why? lost broke other

Dental Insurance

Insurance Co. Name: _____ Group#: _____

Customer Service 1.800 or 1.888 Number: _____ (located on your insurance card)

Who is the insured member in you family? Yourself Spouse Other

Insured's DOB _____ Insured's SS# _____ - _____ - _____

Insured's Employer: _____ Wk#: _____

Has the insured had previous dental care under this plan? No Yes → Date of last dental appointment: _____

Name of Previous Dentist: _____

Dental Claim Agreements

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges to the extent permitted under applicable law, I authorize release of any information relating to any dental claims.

I hereby authorize payment of the dental benefits otherwise payable to me directly to Dr. Jessica H Brigati.

 Patient/Parent Signature



Medical History:

Are you **currently** under the care of a physician? Physicians Name: _____ Phone: _____

Date of Last exam: _____

Do you have a current medical problem? Y/N Explain? _____

Please list any prescription/over-the-counter drugs you are taking:

Name of Medication _____ dosage _____ for _____
 Name of Medication _____ dosage _____ for _____
 Name of Medication _____ dosage _____ for _____
 Name of Medication _____ dosage _____ for _____
 Name of Medication _____ dosage _____ for _____

For Women:

Y / N Are you pregnant? Y / N Nursing? Y / N Using Birth Control Medication?
 Y / N Taking Hormone Medication Y / N Through Menopause

Have you ever had any of the following diseases or medical problems?

- | | | |
|---|---|--|
| Y N AIDS/HIV Positive (circle) | Y N Glaucoma/ Cataracts (circle one) | Y N Scarlet Fever |
| Y N Allergies/Hay Fever (circle) | Y N Heart Murmur/Mitral Valve Prolapse | Y N Shortness of Breath or Swollen Ankles (circle) |
| Y N Anemia | Y N Heart Problems/Chest Pains | Y N Sinus Problems |
| Y N Arthritis | (describe) _____ | Y N Stomach or Digestive Problems |
| Y N Artificial Joints or Prosthetics (circle) | Y N Hearing Problems (left or right ear) | Y N Stroke when _____ |
| (describe) _____ | Y N Herpes/Venereal Disease/ Other STD (circle) | Y N Surgery within the last five years _____ |
| Y N Asthma : Inhaler? _____ | Y N Hepatitis A, B, C (circle one) | Y N Thyroid Trouble |
| Y N Biopsy what _____ when _____ | Y N High/Low Blood Pressure (circle) | Y N Tobacco Habit what form: cigarettes chewing other |
| Y N Cancer/Chemotherapy/Radiation (circle) | Y N Implants (cosmetic or other) | are you currently practicing the above yes no (circle one) |
| Y N Diabetes | what kind _____ when _____ | how long have you been practicing the above: _____ |
| Y N Is your blood sugar monitored daily | Y N Kidney or Urinary Problems | how often do you practice the above |
| Y N Emphysema | Y N Pacemaker: Date of Implantation: _____ | Y N Active or Remote Tuberculosis(TB) (circle one) |
| Y N Epilepsy/Seizures (circle) | Y N Rapid weight gain or loss greater than 10 lbs | Y N Oral or Stomach Ulcer (circle) |
| (frequency) _____ | Y N Rheumatic Fever | Y N Blood Disorder _____ |

Please list any other medical condition(s) and/ or serious illnesses that we should be aware of:

Have you ever had and undesirable or allergic reaction to: (please note what that reaction is)

- | | | | |
|-------------|-------------------------------------|------------------------|---|
| Y N Aspirin | Y N Sulfa Drugs | Y N Dental Anesthetics | Y N Codeine/Valium/ Morphine/ Pain Medication |
| Y N Latex | Y N Penicillin or other antibiotics | Y N Epinephrine | Y N Nickel Y N Other _____ |

How often do you brush your teeth? _____

Do you floss? _____ How Often? _____

Are you happy with teeth and their appearance? Y - N

What, if anything would you change about your teeth/smile if you could? _____

Are you interested in learning about the latest techniques in improving your smile? _____

Do you suffer from frequent headaches? _____ If yes, how often? _____

The information provided today is correct to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical status. I understand that this office will assist me in getting my insurance reimbursement but I am financially responsible for all charges whether or not paid by insurance. Payment is due in full at time of treatment unless prior arrangements have been approved.

Patient/Parent Signature

Date: