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

By typing and/or signing below, 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, DDS, PLLC.

____
Patient/Parent Signature

CONTINUED ON NEXT PAGE

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 Y/N Abnormal Pap Smear Date:__________

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

Y N AIDS/HIV Positive (circle)
Y N Allergies/Hay Fever (circle)
Y N Anemia
Y N Arthritis
Y N Artificial Joints or Prosthetics (circle)
(describe)__________________________
Y N Asthma : Inhaler?_________________
Y N Biopsy what__________ when______
Y N Cancer/Chemotherapy/Radiation (circle)
Y N Diabetes
Y N Is your blood sugar monitored daily
Y N Emphysema
Y N Epilepsy/Seizures (circle)
(frequency)_________________________

Y N Glaucoma/ Cataracts (circle one)
Y N Heart Murmur/Mitral Valve Prolapse
Y N Heart Problems/Chest Pains
(describe)____________________________
Y N Hearing Problems (left or right ear)
Y N Herpes/Venereal Disease/ Other STD *(circle)*
Y N Hepatitis A, B, C (circle one)
Y N HPV (Human Papillomavirus)
Y N High/Low Blood Pressure (circle one)
Y N Implants (cosmetic or other)
what kind ________________when________
Y N Kidney or Urinary Problems
Y N Pacemaker: Date of Implantation: ________
Y N Rapid weight gain or loss greater than 10 lbs

Y N Rheumatic Fever and or Scarlet Feaver
Y N Shortness of Breath or Swollen Ankles (circle)
Y N Sinus Problems
Y N Stomach or Digestive Problems
Y N Stroke when ___________________________
Y N Surgery within the last five years____________
Y N Thyroid Trouble
Y N Tobacco Habit *what form: cigarettes chewing other*
are you currently practicing the above yes no (circle one)
how long have you been practicing the above: _____________
*how often do you practice the above*_____________________
Y N Active or Remote Tuberculosis(TB) (circle one)
Y N Oral or Stomach Ulcer (circle)
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? _______________

By typing or signing below, 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:***