Brentwood Village Dental Clinic – Patient Contact and Medical History Update Form

Name:____ **Today's Date:**__________________________

Have you recently changed your name? **Yes** **No**

If so, what was it before?: ____

Please confirm your date of birth: _______________ / _________________ / _______________
Day Month Year

Please provide your current address with postal code: ____

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Please provide your current telephone numbers:

Home: (______) - ______________ Cell: (______) - ______________ Work: (______) - ______________

Email Address:__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

(Please print your e-mail address clearly in CAPITAL LETTERS) *required for pre-authorizations

Would you like to be on our e-mail mailing list for the monthly Brentwood Village Dental Clinic Newsletter? **Y** **N**

………

Has your insurance changed since your last visit with us? **Yes** **No**

If yes, please provide your new insurance policy details below as well as your insurance card to the front desk.

Full name of policy holder: ____

Insurance Company: ____

Policy Holder's Employer:____
*required for direct insurance billing

Policy/Group #: ______________________ I.D./Certificate #:______________________________

Policy Holder's Date of Birth: /________/________/________/
Day Month Year

Patient's relation to policy holder: **Self** **Spouse** **Common-Law Spouse** **Child** **Full-Time Student** **Other**

………

This is to certify that I, undersigned, consent to the performing of the dental procedures, and/or oral surgery, agreed to be necessary or advisable. I understand that I am responsible for payment on the day of service for any fees not covered by my insurance, unless prior arrangements have been made. I understand that 24 hours notice is needed to rearrange or cancel my reserved appointment time or a cancellation fee may apply. I understand that 5% monthly interest is charged on all unpaid accounts, delinquent for 90 days or more.

I acknowledge that I have read and accept the conditions noted above.

Signature of ***Patient****:*___________________________________*Date:*____________________
(or Legal Guardian if patient is a minor child)

Brentwood Village Dental Clinic – Patient's Medical History

1. Do you have dental phobias and/or are you nervous during dental treatment? Y N

Please rate your anxiety level

1	2	3	4	5	6	7	8	9	10
Little to no anxiety				Some anxiety (manageable)					Extreme anxiety (sedation required)

2. Have you ever been told that you require pre-medication prior to dental procedures? Y N

3. Are you currently taking any prescription medications, non-prescription drugs or herbal supplements of any kind? Y N If yes, please list them:______________________________

____

4. Have you ever been hospitalized for any illnesses or operations? Y N If yes, please list them:_____

____

5. Are you currently having any therapies that could affect your immune system? (i.e. radiotherapy, chemotherapy) Y N If yes, please list them:______________________________

____

6. Do you smoke or chew tobacco products? Y N

If yes, how many cigarettes do you smoke per day?:______________________________

7. Do you now or have you ever had the following:

Heart Disease (heart attack/stroke)............... Y N
Pacemaker.. Y N
Heart Murmur... Y N
Mitral Valve Prolapse.................................. Y N
Heart Valve Replacement or Repair............. Y N
Epilepsy... Y N
Hepatitis A.. Y N
Hepatitis B.. Y N
Hepatitis C.. Y N
Anemia... Y N
Fainting or Dizzy Spells............................... Y N
HIV or AIDS.. Y N
Type 1 Diabetes... Y N
Type 2 Diabetes... Y N
Cancer.. Y N
Organ Transplant.. Y N
Prosthetic or Artificial Joint......................... Y N
Rheumatic Fever... Y N
Osteoporosis.. Y N
Liver Disease.. Y N
Sinus Trouble... Y N
Glandular Disorders...................................... Y N
Low Blood Pressure...................................... Y N
High Blood Pressure..................................... Y N
Lupus... Y N
Herpes.. Y N
Asthma... Y N
Shortness of Breath...................................... Y N
Emphysema.. Y N
Lung Disease.. Y N
Tuberculosis.. Y N
Chest pain, angina.. Y N
Alcohol Dependency.................................... Y N
Drug Dependency... Y N

8. Do you have any medical conditions or diseases that are not listed above? Y N If yes, please list them:______________________________

9. Are you now or have you ever been allergic to any of the following:

Aspirin... Y N
Sulpha Drugs.. Y N
Ibuprophin.. Y N
Local Anesthetics... Y N
Codeine.. Y N
Penicillin.. Y N
Aspirin... Y N
Latex.. Y N

Any allergies not listed: ______________________________

10. Women Only - Are you breastfeeding, pregnant or think you might be?........................ Y N

11. Name & Phone # of your medical doctor: ______________________________