Patient Information

Patient's Name _____ Date_____
Last First Middle

Address _____
Street City State Zip

Home phone _____ Work phone _____ Cell Phone _____

SS# _____ DOB_____ E-mail Address_____

Whom may we thank for referring you to our office? _____

Circle: Responsible Party or Spouse Information

Name _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

Home Phone _____ Work phone _____ Cell phone _____

SS# _____ Birthday _____ Relationship to patient _____

Employer _____ Occupation _____ How long?_____

Please provide receptionist with your dental insurance card and complete the following section.

Primary Ins Information	**Secondary Ins Information**
Employee Name _____	_____
Insurance Co _____	_____
Insurance Co Address _____	_____
(800) _____ SS# _____ GP #_____	(800) _____ SS # _____ GP # _____

Reason for today's visit: Exam □ Emergency □ Consultation □ Other: _____

Are you in pain? □ No □ Yes How Long? _____

Please indicate any of the following problems:

□ Discomfort, clicking or popping in jaw
□ Red, swollen or bleeding gums
□ Blisters/Sores in or around mouth
□ Sensitive tooth, teeth or gums
□ Lost/Broken fillings
□ Locking jaw
□ Ringing in ears
□ Broken/Chipped tooth
□ Stained teeth
□ Bad Breath
□ Teeth Grinding
□ Snoring
□ Other: _____

Previous Dentist: _____ (____)_____
Practice Name/Dr Name Phone #

Times a day you brush? _____ Times a day you floss? _____

What type of toothbrush bristles do you use? □ Soft □ Medium □ Hard

Do you like your smile? □ Yes □ No

Are you interested in whiter teeth? □ Yes □ No

In event of an emergency

Whom should we contact? _____Relation: _____

Home Phone #: (____)_____ Cell phone #: (____)_____ Other #: (____)_____

Medical History

Who is your medical doctor? _____ Phone #: _____Last Visit: _____
Name

Are you under a physician's care now? □Yes □ No If Yes _____

Have you ever been hospitalized or had a major operation? □ Yes □ No If Yes _____

Have you ever had a serious head or neck injury □ Yes □No If Yes _____

Do you take, or have you taken, Phen-fen or Redux? □ Yes □ No

Have you ever taken Fosamax, Boniva, Actonel or any other medication containing bisphosphonates □ Yes □ No

Do you use tobacco? □ Yes □ No If yes, how used? _____

Do you need antibiotics before dental appointment? □ Yes □ No

What medications are you taking? □ Nerve Pills □ Pain Killers (incl. Aspirin) □ Muscle Relaxers
□ Stimulants □ Blood thinners □ Tranquilizers □ Insulin □ Meds for Osteoporosis

List all medications and reasons for use: _____

_____

_____

Medical History continue…

Are you allergic to the following? □ Latex □ Penicillin/Amoxicillin □ Tetracycline □ Aspirin
□ Dental Anesthetics □ Foods: _____ □Others: _____

Do you have a CPAP machine?	□ Yes □ No
Do you awaken unrefreshed or feel sleepy during the day?	□ Yes □ No
Is your snoring loud enough to disturb others?	□ Yes □ No
Have you been told your breathing stops while asleep?	□ Yes □ No
Have you ever had an overnight sleep lab study?	□ Yes □ No
Do you have high blood pressure, take medicine for hypertension, or have a pacemaker?	□ Yes □ No
Do you experience heartburn or acid reflux at night or in the morning?	□ Yes □ No
Do you Notice repetitive limb movements or jerks in sleep, urges to move legs, or night sweat?	□ Yes □ No
Do you experience a dry mouth upon awakening?	□ Yes □ No
Do you have to urinate several times at night? Have you been diagnosed with HBP	□ Yes □ No
Have you had sensitive jaw muscles or joint pain, ringing in your ears, vertigo, or dizziness?	□ Yes □ No
Do you experience Insomnia?	□ Yes □ No
Do you often wake up with a headache?	□ Yes □ No

Do you have, or have you had, any of the following?

□ Acid Reflux
□ AIDS/HIV Positive
□ Alzheimer's disease
□ Anaphylaxis
□ Anemia
□ Angina
□ Arthritis/Gout
□ Artificial Heart Valve
□ Artificial Join
□ Asthma
□ Blood Disease
□ Blood Transfusion
□ Breathing Problem
□ Bruise Easily
□ Cancer
□ Chemotherapy
□ Chest Pains
□ Chronic Fatigue
□ Chronic Pain
□ Cold Sores/Fever Blisters
□ Congenital Heart Disorder
□ Convulsions
□ Cortisone Medicine
□ COPD
□ Depression
□ Diabetes
□ Difficult Sleeping
□ Drug Addiction
□ Easily Winded
□ Emphysema
□ Epilepsy or Seizures
□ Excessive Bleeding
□ Excessive Thirst
□ Fainting Spells/Dizziness
□ Frequent Cough
□ Frequent Diarrhea
□ Frequent Headaches
□ Fibromyalgia
□ Glaucoma
□ Hay Fever
□ Heart Murmur
□ Heart Pace Maker
□ Heart Trouble/Disease
□ Hemophilia
□ Hepatitis A
□ Hepatitis B or C
□ Herpes
□ High Blood Pressure
□ High Cholesterol
□ Hives or Rash
□ HPV
□ Hypoglycemia
□ Insomnia
□ Irregular Heartbeat
□ Kidney Problems
□ Leukemia
□ Liver Disease
□ LBP
□ Lung Disease
□ Mitral Valve Prolapsed
□ Multiple Sclerosis
□ Muscle Twitching
□ Muscular Dystrophy
□ Pain in Jaw Joins
□ Parathyroid Disease
□ Parkinson Disease
□ Psychiatric Care
□ Radiation Treatments
□ Recent Weight Loss
□ Renal Dialysis
□ Rheumatic Fever
□ Rheumatism
□ Scarlet Fever
□ Shingles
□ Sickle Cell Disease
□ Sinus Trouble
□ Sleep Apnea
□ Spinal Bifida
□ Stomach Disease
□ Stroke
□ Swelling of Limbs
□ Thyroid Disease
□ Tonsils removed
□ Tuberculosis
□ Tumors or Growths
□ Ulcers
□ Venereal Disease
□ Wisdom Teeth removed
□ Yellow Jaundice

Other: _____

Please list any other surgeries or medical conditions you have or ever had: _____

We Respect Your Time

Here at Broadway Family Dental Care we have a unique Cancellation/On time policy!!!

Our goal is to provide better, more efficient service for you. For this reason we have implemented a guaranteed "On Time" policy for our patients. **If you are not seated in the clinical area within 15 minutes of your appointment time, we give you a $50 gift certificate.** This is for regular appointments that are scheduled in advanced, not same day or next-day emergencies.

Understandably, it can be frustrating when a patient does not show up for an appointment. Patients who schedule appointments and do not show up are taking away the opportunity for our other valued patients to be seen. What we ask from you is a 48-hour notice of cancellation. For every "No Show' or "Late Cancellation", a $50 fee will be assessed.

Photography Release

I, hereby authorize Broadway Family Dental care to take photographs, slides, and/or videos of my face, jaws, mouth, and teeth.

I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in study club meeting, lectures, seminars, demonstrations, and professional publications.

I further understand my name or other identifying information will be kept confidential.

Initial the following:

_____ Yes, you may use my photos _____ No, please do not use my photos

Office Policy

■ We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly mutual understanding between provider and patient.
■ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
■ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
■ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ **Date**: _____/_____/_____

□Adult □ Parent or Guardian □ Spouse

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