



Today's Date:

Patient's Name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /	Social Security Number:
Address (Street & Apartment #)	Patient Is: <input type="checkbox"/> Minor <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Student <input type="checkbox"/> Widowed	Home Phone ()	Cell Phone: ()
Address (City, State & Zip)		Employed <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Other	Employer:
Email:		Emergency Contact:	Employer Phone: ()
Spouse's or Parent's Name (If patient is a minor)		Emergency Contact Phone: ()	Whom May We Thank for Referring You?

Responsible Party Information:

(This is the account guarantor and this person **MUST** sign below)

Name _____
 Relation to Patient _____
 Address _____
 City _____ State _____ Zip _____
 Birth Date ____/____/____
 Social Security # _____
 Sex Male Female
 Home Phone () _____
 Cell Phone () _____
 Employer _____
 Employer Phone () _____

Dental Insurance Information:

(Please complete information **even if** you've presented a card to us)

Name of Policy Holder _____
 Relation to Patient _____
 Address _____
 Policy Holder's Birth Date ____/____/____
 SS #/Identification #: _____
 Group or Policy # _____
 Policy Holder's Employer _____
 Insurance Company _____
 Phone () _____

Do you have secondary dental insurance coverage? _____: If yes, please present your card to us.

Financial Agreement:

- ✓ I understand payment is due at the time of service. If I have dental insurance, I agree to pay my estimated out-of-pocket expenses at the time of treatment.
- ✓ I understand all balances over 60 days are subject to a 1.5% per month billing charge.
- ✓ I agree to be responsible for all charges which remain unpaid by my insurance after 45 days.

Payment Options:

- ✓ Cash, Check or Credit Card at time of service
- ✓ Extended payment plan (OAC)
- ✓ Auto monthly deduction from credit or debit card
- ✓ Payment in full prior to treatment: 5% discount (cash/check only)

I hereby authorize and direct Brewer Dental Center, as assisted by other dentists and auxiliaries, to perform any necessary dental treatment.

All patients under the age of 18 must have a parent or legal guardian present for all scheduled appointments.

Patient/Guardian Signature (Account Guarantor)

Date

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only

ID:

Address: **Today's Date:** **Date of Last Visit:** **Date of Med. History:**

City State Zip: **Email:**

Home Phone: **Work Phone:** **Birth Date:** **Social Security No.:** **Marital Status:**

Primary Dental Guarantor: **Home Phone:** **Work Phone:**

Secondary Dental Guarantor: **Home Phone:** **Work Phone:**

Physician Name: **Physician Phone:**

Pharmacy: **Pharmacy Phone:**

For Office Use Only

Medical Alerts:

Sex:

If female please answer the following:

Y N
 Are you taking Birth Control Pills?
 Are you pregnant? If Yes, # of weeks
 Are you nursing?

Please answer the following:

Y N
 Do you smoke or use tobacco? Height:
For Office Use Only
 BP Heart Rate: Weight:

Y N <u>Conditions</u>	Y N <u>Conditions</u>	Y N <u>Conditions</u>
<input type="checkbox"/> <input type="checkbox"/> Angina Pectoris	<input type="checkbox"/> <input type="checkbox"/> Other	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> <input type="checkbox"/> Pace Maker	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Paget's Disease	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Bisphosphonates (Fosamax, Boniva)	<input type="checkbox"/> <input type="checkbox"/> Radiation Therapy	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Blood Thinners (Coumadin, Plavix)	<input type="checkbox"/> <input type="checkbox"/> Recreational Drugs	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Respiratory Problems	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Cancer- Chemotherapy	<input type="checkbox"/> <input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Congenital Heart Defect	<input type="checkbox"/> <input type="checkbox"/> Sleep/Snoring Disorder	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Stroke	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Difficult Extractions, Or Bleeding Pr	<input type="checkbox"/> <input type="checkbox"/> Thyroid Problems	
<input type="checkbox"/> <input type="checkbox"/> Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> <input type="checkbox"/> Gastrointestinal Problems		
<input type="checkbox"/> <input type="checkbox"/> Glaucoma		
<input type="checkbox"/> <input type="checkbox"/> HIV+ AIDS		
<input type="checkbox"/> <input type="checkbox"/> Heart Attack		
<input type="checkbox"/> <input type="checkbox"/> Heart Surgery		
<input type="checkbox"/> <input type="checkbox"/> Hepatitis		
<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure		
<input type="checkbox"/> <input type="checkbox"/> Hospitalized In Last 5 Years		
<input type="checkbox"/> <input type="checkbox"/> Joint Replacement		
<input type="checkbox"/> <input type="checkbox"/> Medical Treatment (Currently)		
<input type="checkbox"/> <input type="checkbox"/> Osteoporosis		

Y N Allergies

Aspirin

Codeine

Dental Anesthetics

Erythromycin

Jewelry

Latex

Metals

Penicillin

Tetracycline

Other

Medications:

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Y N

Is there any disease, condition, or problem that you think this office should know about that is not covered above?
If yes, please describe below...

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Notes:

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Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)