BRISTOL *dental, p.c.*

Today's Date _____ / _____ /_____

patient information (confidential)

Full Name _____ Birth Date _____ / _____ /_____

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ SSN# _____-_____-_____ Married ❒ Single ❒ Other ❒

Patient's Employer _____ Phone (_____) _____

Employer's Address _____ City _____ State _____ Zip _____

Person to contact in case of emergency _____ Phone _____

Who may we thank for referring you? _____

responsible party

(If different from patient)

Name of person responsible for this account _____

Relationship to patient _____ Birth Date _____ / _____ /_____

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ SSN# _____-_____-_____ Driver's License _____

Employer's Address _____ City _____ State _____ Zip _____

Work Phone (_____) _____

insurance information

Name of Insured Person _____ Relationship to patient _____

Birth Date _____ / _____ /_____ SSN# _____-_____-_____ Work Phone (_____) _____

Name of Employer _____ Hire Date _____

Employer's Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID# _____

Insurance Co. Address _____

City _____ State _____ Zip _____

We offer the following methods of payment. Please check the option you prefer. **Payment due when services are rendered.**

Cash ❒ Personal Check ❒ MasterCard ❒ Visa ❒ Discover ❒

patient medical history

	YES	NO
Are you under medical treatment now?	❒	❒
Have you ever been hospitalized for any surgical or serious illness within the last 5 years?	❒	❒
If yes, please explain: _____		
Are you taking any medication(s) including non-prescription medicine?	❒	❒
If yes, what medication(s) are you taking? _____		
_____		
Have you ever taken Phen-Fen/Redux?	❒	❒
Do you use tobacco?	❒	❒
Do you use controlled substances?	❒	❒
Are you wearing contact lenses?	❒	❒
Are you allergic to, or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	❒	❒
Penicillin or other Antibiotics	❒	❒
Sulfa Drugs	❒	❒
Barbiturates	❒	❒
Sedatives	❒	❒
Iodine	❒	❒
Aspirin	❒	❒
Any Metals (e.g. nickel, mercury, etc.)	❒	❒
Latex Rubber	❒	❒
Other (please list) _____		

WOMEN ONLY

	YES	NO
Are you pregnant or think you may be pregnant?	❒	❒
Are you nursing?	❒	❒
Are you taking oral contraceptives?	❒	❒

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

	YES	NO		YES	NO		YES	NO
High Blood Pressure	❒	❒	Heart Disease	❒	❒	Chest Pains	❒	❒
Heart Attack	❒	❒	Cardiac Pacemaker	❒	❒	Easily Winded	❒	❒
Rheumatic Fever	❒	❒	Heart Murmur	❒	❒	Stroke	❒	❒
Swollen Ankles	❒	❒	Angina	❒	❒	Hay Fever/Allergies	❒	❒
Fainting/Seizures	❒	❒	Frequently Tired	❒	❒	Tuberculosis	❒	❒
Asthma	❒	❒	Anemia	❒	❒	Radiation Therapy	❒	❒
Low Blood Pressure	❒	❒	Emphysema	❒	❒	Glaucoma	❒	❒
Epilepsy/Convulsions	❒	❒	Cancer	❒	❒	Recent Weight Loss	❒	❒
Leukemia	❒	❒	Arthritis	❒	❒	Liver Disease	❒	❒
Diabetes	❒	❒	Joint Replacement or Implant	❒	❒	Heart Trouble	❒	❒
Kidney Diseases	❒	❒	Hepatitis/Jaundice	❒	❒	Respiratory Problems	❒	❒
AIDS or HIV Infection	❒	❒	Sexually Transmitted Disease	❒	❒	Mitral Valve Prolapse	❒	❒
Thyroid Problem	❒	❒	Stomach Troubles/Ulcers	❒	❒	Other _____		

patient dental history

	YES	NO
Do your gums bleed while brushing or flossing?	❒	❒
Are your teeth sensitive to hot or cold liquids/foods?	❒	❒
Are your teeth sensitive to sweet or sour liquids/foods?	❒	❒
Do you feel pain to any of your teeth?	❒	❒
Do you have any sores or lumps in or near your mouth?	❒	❒
Have you had any head, neck or jaw injuries?	❒	❒
Have you ever experienced any of the following problems in your jaw:		
Clicking	❒	❒
Pain (joint, ear, side of face)?	❒	❒
Difficulty in opening or closing?	❒	❒
Difficulty in chewing?	❒	❒
Do you have frequent headaches?	❒	❒
Do you clench or grind your teeth?	❒	❒
Do you bite your lips or cheeks frequently?	❒	❒
Have you ever had any difficult extractions in the past?	❒	❒
Have you ever had any prolonged bleeding following extractions?	❒	❒
Have you had any orthodontic treatment?	❒	❒
Do you wear dentures or partials?	❒	❒
If yes, date of placement:		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	❒	❒
How would you rate your smile? 1 2 3 4 5 6 7 8 9 10		
Have you been diagnosed with sleep apnea?	❒	❒

authorization & release

I cert☐
answered. I un☐
including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

If I default on payment for which I am responsible and my bill is turned over to collections, I agree to pay collection fees, attorney fees, court costs and interest.

X _____

Signature of patient (or parent, if minor)