WELCOME TO BRISTOL DENTAL GROUP

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available.

PATIENT INFORMATION

Last Name Middle Initial. First Name

Name____

Date of Birth ______________________________ • Male • Female

Address ____ Apt/Unit Number____________

City ________________________ State______ Zip__________________

• Minor • Single • Married • Divorced • Widowed • Separated

Social Security Number___________________

Whom May We Thank for Referring You?____

PERSONAL PHONE NUMBERS INFORMATION

Best Phone number to be contacted between 8am – 5pm: ( ) _________________________

Please circle one: Home Work Cell Phone Other __________________________

Please provide a Secondary phone number where we can contact you: ( ) ___________________

Please circle one: Home Work Cell Phone Other ____________________

RESPONSIBLE PARTY

Name of Person Responsible______________________________

Relation to Patient______________________________________

Address____

Home Phone( )______________________

Social Security _______________________ Driver's License#____________________________

Date of Birth_________________

Currently a Patient in Our Office: • Yes • No

EMERGENCY CONTACT

Person to Contact in Case of Emergency____

Relation ____________________

Best number to contact this person ( ) _________________________

DENTAL HISTORY

Main reason for Today's visit____

Date of last Dental visit/Dental X-ray__________________________

How often do you floss? ________________________ How often do you brush? ___________________

CIRCLE if you have had any of the following:

• Bad breath • Teeth grinding • Sensitivity to heat sweet biting cold • Dry Mouth

• Bleeding gums • Loose teeth or broken fillings • Clicking or popping jaw • Braces

• Gum disease/treatment •Food collection between the teeth • Sores or growths in your mouth

How do you feel about your smile?

Are you experiencing any dental pain or discomfort? •Y •N

Please CIRCLE yes or no:

Condition	Yes / No	Condition	Yes / No
AIDS/HIV positive	○Yes ○No	Cortisone Medicine	○Yes ○No
Alzheimer's disease	○Yes ○No	Diabetes	○Yes ○No
Anaphylaxis	○Yes ○No	Drug Addiction	○Yes ○No
Anemia	○Yes ○No	Easily Winded	○Yes ○No
Angina	○Yes ○No	Emphysema	○Yes ○No
Arthritis/Gout	○Yes ○No	Epilepsy or Seizures	○Yes ○No
Artificial Heart valve	○Yes ○No	Excessive Bleeding	○Yes ○No
Artificial Joint	○Yes ○No	Excessive Thirst	○Yes ○No
Asthma	○Yes ○No	Fainting Spells/Dizziness	○Yes ○No
Blood Disease	○Yes ○No	Frequent Cough	○Yes ○No
Blood transfusion	○Yes ○No	Frequent Diarrhea	○Yes ○No
Breathing problems	○Yes ○No	Frequent Headaches	○Yes ○No
Bruise easily	○Yes ○No	Genital Herpes	○Yes ○No
Cancer	○Yes ○No	Glaucoma	○Yes ○No
Chemotherapy	○Yes ○No	Hay Fever	○Yes ○No
Chest pains	○Yes ○No	Heart Attack/Failure	○Yes ○No
Cold Sores/Fever Blisters	○Yes ○No	Heart Murmur	○Yes ○No
Congenital Heart Disorder	○Yes ○No	Heart Pacemaker	○Yes ○No
Convulsions	○Yes ○No	Heart Trouble/Disease	○Yes ○No
Yellow Jaundice	○Yes ○No	Previous infective endocarditis	○Yes ○No
Repaired CHD with residual defect	○Yes ○No		

Condition	Yes / No	Condition	Yes / No
Hemophilia	○Yes ○No	Radiation Treatments	○Yes ○No
Hepatitis A	○Yes ○No	Recent Weight Loss	○Yes ○No
Hepatitis B or C	○Yes ○No	Renal Dialysis	○Yes ○No
Herpes	○Yes ○No	Rheumatic Fever	○Yes ○No
High Blood Pressure	○Yes ○No	Rheumatism	○Yes ○No
High cholesterol	○Yes ○No	Scarlet Fever	○Yes ○No
Hives or Rash	○Yes ○No	Shingles	○Yes ○No
Hypoglycemia	○Yes ○No	Sickle Cell Disease	○Yes ○No
Irregular Heartbeat	○Yes ○No	Sinus Trouble	○Yes ○No
Kidney Problems	○Yes ○No	Spinal Bifida	○Yes ○No
Leukemia	○Yes ○No	Stomach/Intestinal Disease	○Yes ○No
Liver Disease	○Yes ○No	Stroke	○Yes ○No
Low Blood Pressure	○Yes ○No	Swelling of Limbs	○Yes ○No
Lung Disease	○Yes ○No	Thyroid Disease	○Yes ○No
Mitral Valve Prolapse	○Yes ○No	Tonsillitis	○Yes ○No
Osteoporosis	○Yes ○No	Tuberculosis	○Yes ○No
Pain in Jaw Joints	○Yes ○No	Tumors or Growths	○Yes ○No
Parathyroid Disease	○Yes ○No	Ulcers	○Yes ○No
Psychiatric Care	○Yes ○No	Venereal Disease	○Yes ○No
Damaged valves in transplanted heart	○Yes ○No	Unrepaired cyanotic CHD	○Yes ○No

Have you ever had any serious illness not listed above? ○Yes ○No If yes, describe__________________________

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Medical History

Physician's Name_____________________________________ **Date of last visit** _________________

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ●Y ●N

Artificial (prosthetics) heart valve ●Y ●N Previous infective endocarditis ●Y ●N

Damages valves in transplanted heart ●Y ●N Congenital heart disease(CHD) ●Y ●N

Unrepaired, cyanotic CHD ●Y ●N Repaired (completely) in last 6 months ●Y ●N

Repaired CHD with residual defects ●Y ●N

Except for the conditions listed above, antibiotic prophylaxis is no loger recommended for any other form of CHD

Have you had any serious illnesses or operations? ●Y ●N if yes, describe ____

Are you taking any medications, pills, or drugs? ●Y ●N if yes, ____

Have you had an orthopedic total joint(hip, knee, elbow, finger) replacement? ●Y ●N If yes ______________________________

Have you taken any group of drugs collectively referred to a "fen-phen?" These include combination of Ionimin, Adipex, Fastin (brand names of phentermine). Pondimin (fenfluramine) and Redux (dexfenfluramine). ● Y ●N

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonate for osteoporosis? ● Y ●N

Are you under a physician's care now? ●Y ●N

Have you ever been hospitalized or had a major operation? ●Y ●N If yes ____

Have you ever had a serious head or neck injury? ●Y ●N If yes ____

Are you on a special diet? ●Y ●N if yes ____

Do you use tobacco/Cannabis? ●Y ●N Do you use controlled substances? ●Y ●N

Women: Are you…

○Pregnant/Trying to get pregnant? ○Nursing? ○Taking oral contraceptives

Are you Allergic to any of the following?

• Latex(Rubber) • Penicillin/Antibiotics •Acrylic • Local Anesthetics

• Metal • Aspirin • Sulfa Drugs • Codeine/Narcotics • Hay fever

• Barbiturates, sedatives, or sleeping pills •Iodine • Other

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.
I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance. Initial _________
I authorize the use of this signature on all insurance submission.

Payment is due in full at time of Treatment unless prior arrangements have been approved.

____ ______________
Signature of patient or Signature of guardian if minor Date

I have reviewed this patient's information and medical history.

____ ______________
Dr's Signature Date