Date: ____________________

PERSONAL INFORMATION

Patient's Name: ________________________________ Nickname: ______________
Last Name *First Name* *Middle Name*

Birth Date: ____ / ____ / ______ Age: ____ Gender: ☐ Male ☐ Female SS No.: ____________________
Day *Month* *Year*

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Windowed

Mailing Address: ____
House/Apartment No. *City* *State* *Zip*

Telephone No.: ______________ Cellphone No.: ______________ Email Address: ____________________

Employer: ____ Work No.: ______________

Employer's Address: ________________________________ May we call you at work? ☐ Yes ☐ No

Spouse's Name: ________________________________ Contact No.: ______________
Last Name *First Name* *Middle Name*

INSURANCE INFORMATION

Primary Dental Insurance

Insured Employer: ____________________________

Ins. Co. Name: ____________________________

Address: ____________________________
City *State* *Zip*

Telephone No.: __________ Group No.: __________

Insured's Name: ____________________________

Insured's SS No.: ____________________________

Relation: __________ Birth Date: ____ / ____ / ______
Day *Month* *Year*

Secondary Dental Insurance

Insured Employer: ____________________________

Ins. Co. Name: ____________________________

Address: ____________________________
City *State* *Zip*

Telephone No.: __________ Group No.: __________

Insured's Name: ____________________________

Insured's SS No.: ____________________________

Relation: __________ Birth Date: ____ / ____ / ______
Day *Month* *Year*

ACCOUNT INFORMATION

Name: ____ Relation: ____________________

Billing Address: ____
House/Apartment No. *City* *State* *Zip*

SS No. ______________ Telephone No.: ______________ Mobile No.: ______________

________ (Initial) I hereby authorize assignment of my insurance and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

IN EVENT OF EMERGENCY

Emergency Contact Person: ________________________________ Relation: ______________

Telephone No.: ______________ Work No.: ______________ Cellphone No.: ______________

Medical Doctor: ________________________________ M.D.'s Contact No.: ______________

DENTAL INFORMATION

Do you require **pre-medication**? ☐ Yes ☐ No ☐ I don't know

Please indicate any of the following problems:

☐ Discomfort, clicking or popping in jaw
☐ Red, swollen or bleeding gums
☐ Sensitive tooth, teeth or gums
☐ Blisters/sores in or around the mouth
☐ Lost/broken filings
☐ Teeth grinding
☐ Ringing in ears
☐ Broken/chipped teeth
☐ Stained teeth
☐ Locking jaw
☐ Bad breath

Last Dental Examination: ____ / ____ / _______
Day *Month* *Year*

Last Dental X-rays: ____ / ____ / _______
Day *Month* *Year*

Previous Dentist: ________________________________

Times a day you brush: ______

Times a week you floss: ______

Contact No.: ____________________

MEDICAL HISTORY

Are you currently taking any medication(s)? ☐ Yes ☐ No Please list medication(s): ______________________________

Are you **allergic** to any of the following?

☐ Latex
☐ Penicillin/Amoxicilin
☐ Tetracycline
☐ Aspirin
☐ Dental Anesthetics
☐ Others: ____________________

Are you pregnant? ☐ Yes ☐ No How long? ______ Are you nursing? ☐ Yes ☐ No

Do you have or have you had any of the following diseases, medical conditions or procedures:

Y N Artificial bones/joints
Y N Heart attack/stroke
Y N Heart surgery/pacemaker
Y N Heart murmur
Y N Rheumatic fever
Y N Mitral valve prolapse
Y N Artificial valves
Y N Heart disease
Y N Alcohol/drug abuse
Y N Chest pains
Y N Congenital heart defect
Y N Thyroid problems
Y N Kidney problems
Y N Liver problems
Y N Respiratory problems
Y N Sinus problems
Y N Stomach problems/ulcer
Y N Psychiatric problems
Y N Venereal disease
Y N Cosmetic surgery
Y N Fainting/seizures/epilepsy
Y N Jaw problems TMJ/TMD
Y N Arthritis Rheumatism
Y N Hepatitis
Y N HIV+/AIDS/ARC
Y N Diabetes/Hypoglycemia
Y N Difficulty breathing
Y N Chemotherapy
Y N Frequent neck pain
Y N High/low blood pressure
Y N Cancer/tumor
Y N X-ray or cobalt treatment
Y N Severe/frequent headaches
Y N Asthma
Y N Leukemia
Y N Anemia
Y N Emphysema
Y N Back problems
Y N Glaucoma
Y N Bleeding problems
Y N Shingles
Y N Tuberculosis (TB)
Y N Scarlet fever

Please list any other medical condition(s) you have or ever had: ______________________________

- 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.** Please note, the adult bringing a minor child to our office will be responsible for payment in full for services rendered at the time of visit. It is not our policy to be involved with court ordered judgments (i.e. divorce and child custody issues). 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 agent fees, interest charges, and any other expenses incurred in collecting your account.
- I undestand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes to the information I have provided.

Signature: ________________________________ Date: ____ / ____ / _______

Thomas K. Broering, DDS, INC.
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