BRESSI RANCH
Family Dentistry

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## •Patient Information•

Patient Name: _____ Date:_____
Last First MI
Preferred Name: _____ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____
Social Security #: _____ Birth Date:_____ Driver's Lic #:_____
Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____
(Cell): _____ E-mail: _____ ☐ Yes, I would like email notifications/appt reminders

Address: _____ Other Family Members we have seen:
Street Apartment #
_____ _____
City State Zip Code

Employer Name: _____ Occupation: _____
Address: _____

## •Emergency Contact•

Name: _____ Relationship: _____Phone:_____

## •Health Information•

Date of Last Dental Visit: _____ Reason for this visit: _____

**Have you ever had any of the following? Please check those that apply:**

| | | | |
|---|---|---|---|
| ☐ AIDS/HIV | ☐ Glaucoma | ☐ Pacemaker | ☐ Venereal Disease |
| ☐ Allergic to Latex | ☐ Growths | ☐ Pregnancy | ☐ Codeine Allergy |
| ☐ Allergic to Fluoride | ☐ Hay Fever | Due date:_____ | ☐ Penicillin Allergy |
| ☐ Anemia | ☐ Head Injuries | ☐ Radiation Treatment | OTHER: |
| ☐ Arthritis | ☐ Heart Disease | ☐ Respiratory Problems | ☐ _____ |
| ☐ Artificial Joints | ☐ Heart Murmur | ☐ Rheumatic Fever | ☐ _____ |
| ☐ Asthma | ☐ Hepatitis | ☐ Rheumatism | ☐ _____ |
| ☐ Blood Disease | ☐ High Blood Pressure | ☐ Sinus Problems | ☐ _____ |
| ☐ Cancer | ☐ Jaundice | ☐ Stomach Problems | ☐ _____ |
| ☐ Diabetes | ☐ Kidney Disease | ☐ Stroke | ☐ _____ |
| ☐ Dizziness | ☐ Liver Disease | ☐ Tuberculosis | ☐ _____ |
| ☐ Epilepsy | ☐ Mental Disorders | ☐ Tumors | ☐ _____ |
| ☐ Excessive Bleeding | ☐ Mitral Valve Prolapse | ☐ Thyroid Disease | ☐ _____ |
| ☐ Fainting | ☐ Nervous Disorders | ☐ Ulcers | |

• Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain:_____

• Are you currently taking any medication(s)? ☐ Yes ☐ No If yes, please list: _____
_____

• Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain:_____

• Name of Physician: _____ Phone:_____

• Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain:_____
_____

**To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctor at the next appointment without fail.**

_____ Date:_____
Signature of patient, parent or guardian

## •Spouse or Responsible Party Information•

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____ ☐ Male ☐ Female
Last First MI

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ (Cell): _____

Address: _____
Street City State Zip Code

## •Insurance Information•

**Primary**

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

**Secondary (if Applicable)**

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

## •Referral Information•

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other_____

Name of person or office referring you to our practice: _____

## •Consent for Services•

- ✓ I hereby authorize doctor to take X-rays, study models, photographs, or other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs, unless I have signed the refusal form for x-rays.
- ✓ I authorize doctor to perform all recommended treatment mutually agreed upon by me, for myself or my dependents, and to use the appropriate medication and procedures necessary. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
- ✓ I understand that using anesthetic agents embodies a certain risk.
- ✓ I understand that I have the right to accept or reject dental treatment recommended by Bressi Ranch Family Dentistry. I also understand & accept the potential benefits, risks & complications of any recommended treatment given and I will consider all recommended procedures, alternative treatments or the option of no treatment.
- ✓ I understand that all responsibility for payment of dental services provided in this office for myself or my dependents is my responsibility, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed financial arrangement, I understand that any collection charges may be added to my account which I take full responsibility for.

I understand that the information that I have provided today is accurate to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to advise your office of any changes in the information contained on this form.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party (If applicable)