Brody Family Dental

WELCOME TO OUR OFFICE

REGISTRATION INFORMATION

DATE_____ MEDICAL ALERT_____

The information that is requested on this Questionnaire is essential to providing you with the highest standard of dental care. The protection and privacy of your personal information is important to our office and we are committed to collecting, using and disclosing this information responsibly. **PLEASE PRINT.**

This patient is an:
ADULT__ CHILD__ ADULT UNDER GUARDIANSHIP__ NAME OF GUARDIAN:_____

DR__ MR.__ MRS.__ MS.__ MISS__ REFERRED BY:_____

NAME: _____ _____
LAST FIRST

PREFERS TO BE CALLED _____

ADDRESS:_____
STREET APT# CITY POSTAL CODE

BIRTH DATE: M_____**D**_____**Y**_____ **AGE:**_____ **SEX:**____
HOME PHONE:_____**WORK PHONE:**_____ **CELLPHONE:**_____
EMAIL:_____

MAY WE CALL YOU AT WORK? YES__ NO__
EMPLOYER:_____
PERSON RESPONSIBLE FOR THE
ACCOUNT:_____
NAME OF SPOUSE:_____
DO YOU HAVE DENTAL INSURANCE? YES__ NO__
INSURANCE COMPANY_____
POLICY#_____CERTIFICATE#_____

FAMILY PHYSICIAN:
NAME_____ADDRESS:_____
PHONE NUMBER:_____
ARE YOU UNDER THE CARE OF A MEDICAL SPECIALIST? YES__ NO__
IN CASE OF EMERGENCY, PLEASE
CONTACT:_____PHONE:_____

DENTAL HISTORY:

CHECK YES OR NO	YES	NO
1) HAVE YOU BEEN SEEING A DENTIST REGULARLY?	___	___
2) HAVE YOU EVER HAD ANY OF THE FOLLOWING?		
-Periodontal treatment (Gum treatment)	___	___
-Orthodontic treatment (realign teeth)	___	___
-A bite plate or any other appliance	___	___
-Oral surgery?	___	___
3) ARE THERE ANY GROWTHS OR SORE SPOTS IN YOUR MOUTH?	___	___
4) DO YOUR GUMS BLEED WHEN BRUSHING OR EATING?	___	___
OR DO YOU SUFFER FROM PAIN OR SWELLING OF YOUR GUMS?	___	___
5) HAVE YOU NOTICED ANY LOOSE TEETH, OR HAVE ANY TEETH SHIFTED?	___	___
6) DOES FOOD CATCH BETWEEN YOUR TEETH?	___	___
7) ARE ANY OF YOUR TEETH SENSITIVE TO HEAT, COLD, SWEETS OR PRESSURE?	___	___
8) HAVE YOU BEEN ADVISED TO TAKE ANTIBIOTICS BEFORE A DENTAL APPOINTMENT?	___	___
9) DO YOU USE DENTAL FLOSS?	___	___
10) HOW OFTEN DO YOU BRUSH YOUR TEETH? _____		
DO YOU HAVE BAD BREATH?	___	___
11) HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS?		
-Popping/clicking in your jaw joints?	___	___
-Pain in your jaws joints, around your ear, or side of your face	___	___
-Difficulty in opening or closing?	___	___
-Pain when teeth are clenched?	___	___
-Pain or difficulty while chewing?	___	___
12) DO YOU HAVE ANY OF THE FOLLOWING HABITS?		
_ Clenching or grinding your teeth while awake/sleep	___	___
_ Biting your cheeks or lips?	___	___
_ Mouth breathing while awake/sleep	___	___
_Placing foreign objects in your mouth (pencils, nails, pins etc)	___	___
13) DO YOU HAVE ANY EMOTIONAL CONCERNS ABOUT HAVING DENTAL TREATMENT?	___	___
14) ARE YOU DISSATISFIED WITH THE APPEARANCE OF YOUR TEETH?	___	___
15) HAVE YOU EVER HAD AN UPSETTING EXPERIENCE IN A DENTAL OFFICE, OR ANY COMPLICATIONS DURING OR FOLLOWING DENTAL TREATMENT, OR DO YOU HAVE ANY QUESTIONS OR CONCERNS?	___	___

GENERAL RELEASE

I, the undersigned, certify that I have provided and accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical-dental history. **Should there be any change in either health status or any other information I have provided, I will advise this dental office.** I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

X_____ _____

PATIENT/PARENT/GUARDIAN (PRINT NAME OF GUARDIAN)