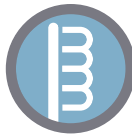


BREAUX BRIDGE
FAMILY DENTISTRY

WELCOME - TELL US ABOUT YOURSELF

Name: ____
Last First Middle Title

Preferred Name: ____

Address: ____

City: ____________________ State: ____________________ Zip: ____________

SSN (optional): ____________________ DOB: ____________________

Home Phone: ____________________ Work Phone: ____________________

Cell Phone: ____________________ Email Address: ____________________

Employer: ____________________ Occupation: ____________________

Marital Status: Single | Married | Divorced | Separated | Widowed | Domestic Partner

How did you hear about us? TV | Radio | Newspaper | Website | Word of Mouth | Other: ____________

How do you prefer to be contacted for appointment confirmation? Email | Phone

INSURANCE - PRIMARY

Subscriber Name: ____________________ Relationship to Patient: ____________ Subscriber DOB: ________

Subscriber SSN/ID: ____________________ Subscriber Employer: ____________________

Insurance Company Name: ____

Insurance Company Address: ____

Insurance Company Phone: ____________________ Group Number: ____________________

INSURANCE - SECONDARY

Subscriber Name: ____________________ Relationship to Patient: ____________ Subscriber DOB: ________

Subscriber SSN/ID: ____________________ Subscriber Employer: ____________________

Insurance Company Name: ____

Insurance Company Address: ____

Insurance Company Phone: ____________________ Group Number: ____________________

Assignment & Release

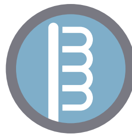
I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Breaux Bridge Family Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I here authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: ____

Relationship: ____________________ Date: ____________________

Consent: I consent to the diagnostic procedures and treatment by the dentist for proper dental care.

Patient/Guardian Signature: ____



BREAUX BRIDGE
FAMILY DENTISTRY

MEDICAL HISTORY

Your current physical health is: Good | Fair | Poor

Are you currently under the care of a physician? Yes | No

If yes, why? ______________________________

Physician's Name: ______________________________

Physician's Phone: ______________________________

Date of last visit: ______________________________

Do you use tobacco in any form? Yes | No

Are you taking any medications? Yes | No

Please list each one: ______________________________

____

____

Conditions

- ☐ Abnormal bleeding
- ☐ Alcohol Abuse
- ☐ Allergies
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Facial Surgery
- ☐ Fainting Spells
- ☐ Fever Blisters
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ HIV+AIDS
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ Joint Replacement
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolaspe
- ☐ Pace Maker
- ☐ Psychiatric Problems
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Jewelry
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Tetracycline
- ☐ Other ____________

If Female Please Answer:

Are you taking Birth Control? Yes | No

Are You Pregnant? Yes | No If so, # of weeks _______

Are you nursing? Yes | No

Nearest relative not living with you (Emergency Contact):

Name: ______________________________ Relationship: ______________

Address: ______________________________ Phone: ______________

I understand that the information that I have given is correct 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 inform this office of any changes in my medical status.

Signature: ______________________________ Date: ______________