



Patient's Name: \_\_\_\_\_ How do you prefer to be addressed? \_\_\_\_\_ Sex (Circle One): Male Female
Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_ Marital Status (Circle One): Single Married Widowed Separated Divorced
SS#: \_\_\_\_\_ Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
E-mail: \_\_\_\_\_ Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_\_) \_\_\_\_\_
Dental Insurance Carrier: \_\_\_\_\_ Policy Holder: \_\_\_\_\_ Policy Holder DOB: \_\_\_\_\_
Insurance ID Number: \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_
If Student, Name of School/College: PT FT \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
Who can we thank for referring you to our office? \_\_\_\_\_

If the person responsible for payment is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise, please skip.

Name of Responsible Party: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
E-mail: \_\_\_\_\_ Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_\_) \_\_\_\_\_
Work Phone: (\_\_\_\_\_) \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Medical History

Date of last complete physical: \_\_\_\_\_ Medical Doctor's Name: \_\_\_\_\_ Doctor's Phone #:(\_\_\_\_\_) \_\_\_\_\_
Are you taking any medication, vitamins, or supplements? Bisphosphonates? Yes/No Please list: \_\_\_\_\_
Do you smoke? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how much a day? \_\_\_\_\_
Are you pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how many months? \_\_\_\_\_
Are you allergic to: (Select all that apply) Penicillin Codeine Local injected anesthetic Latex Other: \_\_\_\_\_
Please describe any current treatment, impending operation, or any other medical or dental condition that you have.

Have you been told that you need to take antibiotics prior to dental cleanings or other treatment? Yes \_\_\_ No \_\_\_

Medication & Reason: \_\_\_\_\_

Do you have or have you ever had any of the following? Check all that apply:

- Heart attack, Anemia, Ulcers, Excessive urination, Soreness in jaw
Heart murmur, Prolonged bleeding, Herpes, Sensitivity to epinephrine, Is it hard for you to open wide?
Heart condition, High or low blood pressure, AIDS/HIV positive, Implants, Snoring
MVP, Asthma, Headaches/Migraines, Dry mouth
Pacemaker, Diabetes, Hay fever, Pain/Soreness (circle one), Bad breath or sour taste
Stroke, Hepatitis, Sinus trouble, ears, eyes, face, Sensitivity to hot and cold
Malignancies, Jaundice, Persistent cough, Stiff neck, jaw pain, or TMJ (circle one), Burning sensations in mouth
Radiation treatments, Arthritis, Psychiatric care or Nervous problems, Clicking or popping in jaw, Bleeding gums
Thyroid Disease, Rheumatism, Nervous problems, Clicking or popping in jaw, Food catching between teeth
Epilepsy, Joint replacements, Narrow angle glaucoma, COVID-19; Date of positive test result: \_\_\_\_\_

What is most important to you about your teeth? \_\_\_\_\_

How would you rate the appearance of your smile? (Select one) Excellent [ ] Good [ ] Fair [ ] Poor [ ]

If you could change anything about your smile, what would it be? \_\_\_\_\_

Does having dental treatment make you afraid or nervous? Y [ ] N [ ] If yes, what specific things bother you? \_\_\_\_\_

Communication Preferences:

[ ] Do not leave a detailed message [ ] Office may leave a detailed message which may contain medical/dental information at the following phone number(s): [ ] Cell [ ] Home

Is there anyone other than the patient we may speak to regarding any dental treatment information?

Name of Person: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

I certify that all the information (including medical, personal, and insurance records) is true and complete. I give my full permission to Dental Care Bridgewater to check and verify my credit and/or employment history. I further understand that Dental Care Bridgewater will assist me in filing my claims, but the insurance coverage I have for dental services can vary and will depend on my insurance plan. I understand that I am responsible for all fees and services. Since our doctors often provide continuing education to other doctors, I give my permission to use my photos for educational purposes. I give permission for phone calls and visits to be recorded for internal training purposes. If the patient is a minor, as the responsible party I give permission, in my absence, to provide examinations, dental cleanings and necessary x-rays as part of routine care for this patient. We require 48 hours advance notice if you are unable to keep your appointment. Failure to do so could result in a charge. Finance charges will be assessed on any account that is 60 days or more past due at the rate of 1.5% per month. Thank you for your cooperation.

I agree that, should I test positive for COVID-19 within 14 days following my dental appointment, I will immediately contact my doctor.

Signature of Patient or Guardian: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_