WELCOME TO Bram Dental

Date: _____

Name: ☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms. _____

Date of Birth: _____ Age _____ SSN: _____ Home #: _____

Cell #: _____ May we text you? ☐ yes ☐ no Cell Carrier: _____

Current Address: _____ City: _____ State: ____ Zip: _____

Can we contact you via email: ☐ yes ☐ no Email: _____

Employer: _____ Occupation: _____ Work # _____

Address: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Whom may we thank for referring you: _____

PRIMARY INSURANCE

Insured's Name: _____ Relation to Patient: _____ Birthdate: _____

Insurance Company: _____

ID#: _____ Group#: _____ Phone: _____

Names of other dependents covered under this plan: _____

ADDITIONAL INSURANCE

Insured's Name: _____ Relation to Patient: _____ Birthdate: _____

Insurance Company: _____

ID#: _____ Group#: _____ Phone: _____

DENTAL HISTORY

Reason For today's visit: _____ Date of last dental exam: _____

Former Dentist: _____ Date of last dental X-rays: _____

Address: _____ Telephone # _____

Check If you have or had any of the following:

☐ Bad breath	☐ Loose teeth	☐ Sensitivity to sweets	☐ Bleeding gums
☐ Broken fillings	☐ Sensitivity to biting	☐ Clicking or popping jaw	☐ Periodontal treatment
☐ Sores or growths in mouth	☐ Sensitivity to cold	☐ Diagnosed with TMJ	☐ Grinding teeth
☐ Sensitivity to heat	☐ Food collection between teeth		

How often do you brush? _____ How often do you floss? _____

Do you use ☐ electrical toothbrush ☐ manual toothbrush?

Is there anything you would like to change about your smile? _____

MEDICAL HISTORY

Primary Care Physician: _____ Date of last visit: _____

Physician's Address: _____ Phone: _____

Have you ever had any serious illnesses or surgeries? ____ if yes explain _____

_____

Have you ever had a blood transfusion? ____ if yes explain _____

Women: ☐ Are you Pregnant? ☐ Nursing? ☐ Taking Birth Control?

→

PLEASE COMPLETE BOTH SIDES

MEDICAL HISTORY

Check if you have or had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints *
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Any Type Of Transplant*
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur*
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Any Type Of Implant*
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse*
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever*
- ☐ Steroid Treatment
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet/Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

*Antibiotic pre-medication may be required prior to your appointment.

If you have checked any of the above, please provide a brief description: _____

Please list **ALL** your medications, including over the counter and herbal remedies.

Medication	Reason for Taking	Medication	Reason for Taking
1		6	
2		7	
3		8	
4		9	
5		10	

Are you currently taking any Blood thinners (IE. Coumadin, Aspirin)? _____

Are you currently taking any Bisphosphonates (IE. Fosamax, Boniva)? _____

ALLERGIES

- ☐ Aspirin
- ☐ Penicillin
- ☐ Barbiturates
- ☐ Latex
- ☐ Sulfa
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Metals

Other: _____

I certify that I have read and understand the above information to the best of my knowledge The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including my diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to a third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

➔ _____ _____

Signature of Patient or Guardian Date