



Michael P. Bryan, DDS

A Family Dental Practice

THE BENEFITS OF A HEALTHY SMILE ARE IMMEASUREABLE! PLEASE FILL OUT THIS FORM COMPLETELY. THE BETTER WE COMMUNICATE THE BETTER WE CAN CARE FOR YOU!

PATIENT INFORMATION

NAME _____ **MR/MRS./MS** **I prefer to be called** _____
LAST FIRST MIDDLE (circle)

ADDRESS _____
STREET CITY STATE ZIPCODE

BIRTHDAY _____ **SOCIAL SECURITY #** _____ **MALE** **FEMALE**

E-MAIL ADDRESS _____

HOME PHONE _____ **CELL PHONE** _____ **WORK PHONE** _____

EMPLOYER _____
ADDRESS

WHOM MAY WE THANK FOR REFERING YOU? _____

OTHER FAMILY MEMBERS BEING SEEN BY US? _____

SPOUSE INFORMATION

NAME (LAST, FIRST, MI) _____ **DATE OF BIRTH** _____ **SOCIAL SECURITY #** _____

EMPLOYER _____ **PHONE#** _____ **WORK#** _____

INSURANCE INFORMATION

INSURED NAME _____ **ID#** _____ **DATE OF BIRTH** _____

INSURED EMPLOYER _____ **INSURANCE CO. NAME** _____

ADDRESS _____ **GROUP #(ID, POLICY#)** _____

GETTING TO KNOW YOU

1. Previous Dentist _____ Last visit _____ Last X-rays _____
2. Why did you leave your previous dentist? _____
3. Have you or anyone in your family had difficulty with anesthesia? _____
4. Are you nervous about, or had an unfavorable experience regarding dental treatment? _____
5. Have you ever had to use Antibiotics before a dental procedure? _____
6. If you could change anything about your smile what would it be? _____
7. Have you ever taken prescribed or over-the-counter diet medications (Fen-phen, Redux)? _____

8. Do you have any clicking/popping in your jaw? _____ 9. Do you currently use tobacco products? _____
10. (Women) Are you pregnant, nursing or taking birth control medication? _____
11. Do you frequently have a bad taste in mouth? _____
12. Are you having any pain, or do you have a problem which concerns you? _____
13. Why are you coming to see us?(i.e. pain, check up, etc.) _____
14. Name and address of physician _____ Phone# _____

HEALTH HISTORY

<i>Heart Failure</i>	YES	NO	<i>Artificial Joints</i>	YES	NO	<i>Drug Dependency</i>	YES	NO
<i>Heart Disease</i>	YES	NO	<i>Thyroid Problems</i>	YES	NO	<i>Venereal Disease</i>	YES	NO
<i>Chest Pain</i>	YES	NO	<i>Cancer</i>	YES	NO	<i>Stroke</i>	YES	NO
<i>Heart Murmur</i>	YES	NO	<i>Emphysema</i>	YES	NO	<i>Shortness of Breath</i>	YES	NO
<i>High Blood Pressure</i>	YES	NO	<i>Chronic Cough</i>	YES	NO	<i>Kidney Disease</i>	YES	NO
<i>Mitral Valve Prolapse</i>	YES	NO	<i>Tuberculosis</i>	YES	NO	<i>HIV Positive/ Aids</i>	YES	NO
<i>Artificial Heart Valve</i>	YES	NO	<i>Asthma</i>	YES	NO	<i>Ulcers</i>	YES	NO
<i>Pacemaker</i>	YES	NO	<i>Seasonal Allergies</i>	YES	NO	<i>Cold sores/ Fever Blister</i>	YES	NO
<i>Heart Surgery</i>	YES	NO	<i>Sinus Trouble</i>	YES	NO	<i>Diabetes</i>	YES	NO
<i>Rheumatic Fever</i>	YES	NO	<i>Radiation Therapy</i>	YES	NO	<i>Epilepsy or Seizures</i>	YES	NO
<i>Arthritis/Rheumatism</i>	YES	NO	<i>Chemotherapy</i>	YES	NO	<i>Hemophilia</i>	YES	NO
<i>Cortisone Medicine</i>	YES	NO	<i>Latex Sensitivity/Allergy</i>	YES	NO	<i>Hepatitis A, B, C or other</i>	YES	NO

Do you have or have you had any disease, condition, or problem not listed? _____

Are you allergic to any medications, foods, or preservatives? _____

Have you been hospitalized during the past two years? _____

List Current Medications/ Supplements: _____

CONSENT

I understand the above information is necessary to provide me with dental care in a safe and efficient manner, and have answered all questions to the best of my knowledge. If I ever have any changes I will inform you at the next appointment.

I hereby authorize release of any information needed and also authorize my insurance company to pay directly to this office benefits accruing to me under my policy. I UNDERSTAND THERE MAY BE A CHARGE FOR ANY MISSED APPOINTMENTS NOT CANCELLED 48 HOURS PRIOR TO APPOINTMENT TIME.

Patient Signature: _____ Date: _____

HEALTH HISTORY UPDATE

PLEASE INDICATE BELOW ANY CHANGES IN YOUR HEALTH, INSURANCE OR CONTACT INFORMATION:

CHANGES _____ INITIAL/DATE _____

CHANGES _____ INITIAL/DATE _____

CHANGES _____ INITIAL/DATE _____

CHANGES _____ INITIAL/DATE _____

CHANGES _____ INITIAL/DATE _____

CHANGES _____ INITIAL/DATE _____