Brandenburg Family Dentistry, PPLC

Dr. William P. Denton, DMD |1120 High Street | Brandenburg, KY 40108

CONFIDENTIAL MEDICAL HISTORY

DENTAL HISTORY

Reason for Today's Visit _____ Date of Last Dental Care _____

Former Dentist _____ Date of Last Dental Checkup _____

Check "Yes" or "No" to indicate if you have had problems with any of the following:

Bad Breath	☐ Yes	☐ No	Food collection between teeth	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
Bleeding Gums	☐ Yes	☐ No				Pain around ear	☐ Yes	☐ No
Blisters on Lips or Mouth	☐ Yes	☐ No	Foreign objects, piercing	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No	Grinding teeth	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No	Gums swollen or tender	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
Cigarette, pipe, smokeless tobacco, or cigar smoking	☐ Yes	☐ No	Jaw pain or tenderness	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
			Lip or cheek biting	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No	Loose teeth / broken fillings	☐ Yes	☐ No	Sores/growths in mouth	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No	How often do you floss? _____		
Fingernail biting	☐ Yes	☐ No	Mouth pain, brushing	☐ Yes	☐ No	How often do you brush? _____		

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you ever been informed that you need pre-medication prior to dental treatment? ☐ Yes ☐ No Doctor's Name _____

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe. _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates. _____

WOMEN: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check if you have or have had any of the following:

Anemia	☐ Yes	☐ No	Cortisone Treatments	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Cough, Persistent	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Cough Up Blood	☐ Yes	☐ No	HIV/AIDS	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Swelling Feet/Ankles	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Fainting	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Tobacco Habit	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No

Any other condition or illness not listed? _____

MEDICATIONS

List medications you are currently taking. _____

_____

_____

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

☐ Ibuprofen
☐ Codeine
☐ Penicillin
☐ Sulfa
☐ Latex
☐ None
☐ Other _____

SIGNATURE

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or if my medications change, I will inform the doctor at the next dental appointment without fail.

_____ _____

Signature of Responsible Party Date

Brandenburg Family Dentistry, PPLC

Dr. William P. Denton, DMD |1120 High Street | Brandenburg, KY 40108

Patient Information

DATE _____

AGE _____

NAME _____ ☐ MARRIED ☐ SINGLE ☐ MINOR ☐MALE ☐ FEMALE
LAST FIRST MIDDLE

ADDRESS _____
STREET APT. NO. CITY STATE ZIP

BIRTHDATE _____ PHONE _____ _____
MONTH DAY YEAR HOME WORK

EMAIL ADDRESS _____ WOULD YOU LIKE TO BE CONTACTED BY EMAIL? ☐ YES ☐ NO

EMPLOYER (OR SCHOOL) _____ GRADE _____ SSN _____

DENTAL INSURANCE COMPANY _____ GROUP NO. _____

HAS ANY MEMBER OF YOUR FAMILY EVER BEEN TREATED IN OUR OFFICE? ☐ YES ☐ NO

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

Family Information

PARENT, GUARDIAN, OR SPOUSE

NAME _____
LAST FIRST MIDDLE

ADDRESS _____
STREET CITY STATE ZIP

BIRTHDATE & SSN _____
MM/DD/YYYY SSN

EMPLOYER _____

DENTAL INSURANCE CO. _____

GROUP NO. _____

PARENT OR GUARDIAN IF APPLICABLE

NAME _____
LAST FIRST MIDDLE

ADDRESS _____
STREET CITY STATE ZIP

BIRTHDATE & SSN _____
MM/DD/YYYY SSN

EMPLOYER _____

DENTAL INSURANCE CO. _____

GROUP NO. _____

Person Responsible for Account ☐ PATIENT ☐ PARENT OR SPOUSE ☐ GUARDIAN

Person to Contact Outside of Immediate Family in Case of Emergency

NAME _____ PHONE _____

ADDRESS _____

Method of Payment ☐ CREDIT CARD ☐ CHECK ☐ CASH ☐ INSURANCE (your portion due today)

Agreement

Insurance – I understand that the portion of my treatment not covered by insurance is due and payable at each visit. I also understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the dentist, and that I am still responsible for all dental fees. If my insurance company has not paid their portion within 30 days of being properly billed, I understand that the balance will become due and payable from me.

Service Charge – If I do not pay the entire New Balance (the "Amount Due Now" on your statement) within 30 days of the date of service, a service charge will be added to my account for the current monthly billing period. The service charge will be a periodic rate of 2% per month which is an annual percentage rate of 24%. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection agency costs and reasonable attorney fees incurred to effect collection on this account.

Consent

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medications, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance charge will be added to any overdue balance. I also assign all insurance benefits to the Doctor and authorize the release of any information to my insurance company for consideration of claims to be processed.

Signature of Responsible Party _____