Cypresswood Family Dental, PA

Michael M. Brymer, DDS

PATIENT INFORMATION

Date_____

Name _____ ❑ Married ❑ Single ❑ Minor ❑ Male ❑ Female
First M. Last

Preferred or Nick Name _____Date of Birth _____ Age _____
Month Day Year

Address _____
Street Apt. # City State Zip

Home # _____ Work # _____ Cell # _____

Employer _____ SS# _____

If College Student, Name of School _____Email _____

Has any member of your family been a patient in our office? ❑ Yes ❑ No If Yes who? _____

How did you hear about our office? ❑ Friend/Family ❑ Yellow Pages ❑ Drive By ❑ Internet ❑ Other

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY

Person responsible for this account _____ Relationship to patient _____

Address _____ Home Phone _____

Driver's License # _____Birthdate _____ SS# _____

Employer _____Work # _____

Is this person currently a patient in our office? ❑ Yes ❑ No

INSURANCE INFORMATION

Name of Insured _____ Relationship to patient _____

Birthdate _____ SS# _____

Name of Employer _____Work # _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Co. _____Tel. # _____Grp # _____ Policy/ID # _____

Ins. Co. Address _____City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit? _____

Do you have a secondary dental insurance policy? ❑ Yes ❑ No If yes, please provide receptionist with necessary information.

EMERGENCY CONTACT

Name _____

Home # _____

Cell # _____

METHOD OF PAYMENT

Payment is due at the time of service. I will be paying by:

❑ Cash or personal check ❑ Visa ❑ MC

Card # _____ Exp. Date _____

CONSENT

I have read and answered the above questions to the best of my knowledge. I consent to an oral examination, diagnostic procedures, x-rays, and treatment to be provided by the doctors and staff of Cypresswood Family Dental, PA I also authorize the use of photographs to document my dental/oral condition.

_____ _____

SIGNATURE: PATIENT/GUARDIAN DATE

Cypresswood Family Dental, PA

Michael M. Brymer, DDS

Dental History

Date _____

Name _____ Age _____

Former Dentist _____

Reason for today's visit _____

Date of last exam _____ Date of last dental X-rays _____

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

Please check any of the following conditions that apply to you:

- ❑ Bad Breath
- ❑ Bleeding gums
- ❑ Clicking or popping jaw
- ❑ Food collection between teeth
- ❑ Grinding teeth
- ❑ Loose teeth or broken filings
- ❑ Peridontal treatment
- ❑ Sensitivity to cold
- ❑ Sensitivity to hot
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Sores or growths in your mouth

Medical History

Physician_____ Telephone # _____

Cardiologist_____ Telephone # _____

Are you taking a blood thinner? ❑ Yes ❑ No Drug _____

Have you been a patient in a hospital in the past 5 years? ❑ Yes ❑ No Reason _____

Have you ever had any serious illness or operations? ❑ Yes ❑ No Reason _____

(Women) Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking Birth Control Pills? ❑ Yes ❑ No

Please check if you have any of the following:

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

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

- ❑ Aspirin
- ❑ Barbituates (sleeping pills)
- ❑ Codeine
- ❑ Erythromycin
- ❑ Iodine
- ❑ Latex
- ❑ Local Anesthetic
- ❑ Penicillin
- ❑ Sulfa
- ❑ Other _____

_____

_____

Authorizations

I certify that I have read and understand the above information. I have answered all questions accurately and to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners.

_____ _____

SIGNATURE: PATIENT/GUARDIAN DATE