Birkitt Dental

Welcome to Our Practice!

Please take a few minutes to answer the following questions so that we may better assist you with your oral health needs:

Patient Information

Name: _____

SS#: _____ Birthdate: _____

Home Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: ____ Zip: _____ E-mail: _____

Sex: ☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Long-term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer: _____ Business Phone: _____

Who should we thank for referring you? _____

Emergency Contact: _____ Phone: _____

Responsible Party Information

Name (if different from above): _____

Relationship to Patient: _____ Birthdate: _____ SS#: _____

Home Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: ____ Zip: _____ E-mail: _____

Employer: _____ Yrs. Employed: _____

Occupation: _____ Business Phone: _____

Business Address: _____

City: _____ State: ____ Zip: _____ E-mail: _____

Insurance Information

Insured Name: _____

Relationship to Patient: _____ Birthdate: _____ SS#: _____

Home Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: ____ Zip: _____ E-mail: _____

Insurance Company: _____

Insurance Company Address: _____

Subscriber I.D.#: _____ Group#: _____

Assignment and Release

I hereby authorize payment directly to Cary T. Birkitt, D.D.S., Ltd. for all insurance benefits otherwise payabe to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize Cary T. Birkitt, D.D.S. and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: _____ Date: _____

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PLEASE COMPLETE REVERSE SIDE

Health History Information

Dental History

Former Dentist:_____ Date of Last X-Rays: _____

City, State:_____ How Often Do You Floss? _____

Date of Last Dental Visit: _____ How Often Do You Brush? _____

Please check all that apply:

- Bad Breath ☐
- Bleeding Gums ☐
- Blisters on Lips or Mouth ☐
- Finger Nail Biting ☐
- Grinding Teeth ☐
- Lip or Cheek Biting ☐
- Loose Teeth or Broken Fillings ☐
- Orthodontic Treatment ☐
- Pain Around Ear ☐
- Periodontal Treatment ☐
- Sensitivity to Cold ☐
- Sensitivity to Heat ☐
- Sensitivity to Sweets ☐
- Sensitivity When Biting ☐
- Frequent Headaches ☐
- Jaw, Head or Neck Injuries ☐
- Jaw Difficulty: Clicking and/or Pain ☐
- Tooth Pain ☐

Medical History

Physician's Name: _____ Date of Last Visit _____

	Yes	No
1. Are you currently under medical treatment?	◯	◯
2. Have you ever had any serious illnesses or operations?	◯	◯
3. Are you currently taking any medication?	◯	◯
Please describe_____		
_____		
4. Do you smoke?	◯	◯
5. Do you use alcohol?	◯	◯
6. Do you use cocaine?	◯	◯
7. Do use other drugs	◯	◯
Please describe_____		
_____		
8. Do you wear contact lenses?	◯	◯

9. Have you had any allergic reaction to the following:	Yes	No
Local Anesthetics (e.g., novocaine)?	◯	◯
Penicillin or other Antibiotics?	◯	◯
Sulfa Drugs?	◯	◯
Barbiturates (sleeping pills)?	◯	◯
Sedatives?	◯	◯
Iodine?	◯	◯
Aspirin?	◯	◯
Other?	◯	◯
10. (Women Only) Are You:		
Pregnant?	◯	◯
Nursing?	◯	◯
Taking birth control pills?	◯	◯

Please check all that apply:

- AIDS ☐
- Anemia ☐
- Arthritis, Rheumatism ☐
- Artificial Heart Valves ☐
- Artificial Joints ☐
- Asthma ☐
- Back Problems ☐
- Bleeding abnormally, with extractions or surgery ☐
- Blood Disease ☐
- Cancer ☐
- Chemical Dependency ☐
- Chemotherapy ☐
- Chronic Fatigue Syndrome ☐
- Circulatory Problems ☐
- Congenital Heart Lesions ☐
- Cortisone Treatments ☐
- Cough—persistent or bloody ☐
- Diabetes ☐
- Emphysema ☐
- Epilepsy ☐
- Fainting or Dizziness ☐
- Glaucoma ☐
- Headaches ☐
- Heart Murmur ☐
- Heart Problems ☐
- Hepatitis Type _____ ☐
- Herpes ☐
- High Blood Pressure ☐
- HIV Positive ☐
- Jaundice ☐
- Jaw Pain ☐
- Latex Sensitivity ☐
- Kidney Disease ☐
- Liver Disease ☐
- Low Blood Pressure ☐
- Mitral Valve Prolapse ☐
- Nervous Problems ☐
- Pacemaker ☐
- Psychiatric Care ☐
- Radiation Treatment ☐
- Respiratory Disease ☐
- Rheumatic Fever ☐
- Scarlet Fever ☐
- Shortness of Breath ☐
- Sinus Trouble ☐
- Skin Rash ☐
- Stroke ☐
- Swelling of Feet/Ankles ☐
- Swollen Neck Glands ☐
- Thyroid Problems ☐
- Tonsillitis ☐
- Tuberculosis ☐
- Tumor or growth on head/neck ☐
- Ulcer ☐
- Venereal Disease ☐