BRIGHAM DENTAL CARE

MATTHEW EBERT, DMD

58 BRIGHAM STREET
MORRISVILLE, VT 05661

MEDICAL AND DENTAL HISTORY

*DATE:*_____

Name: _____
❑ Mr ❑ Mrs ❑ Ms ❑ Dr

Preferred name _____

Birth date _____/_____/_____ Age _____

Address _____ PO Box _____

_____ Zip _____

❑ single ❑ married ❑ divorced ❑ widowed ❑ separated

Home # _____ Work # _____ Ext ____

Cell # _____ Email _____

Employer _____

Address _____

Occupation _____

Where and when is best to reach you? _____

_____

Person to notify in case of emergency

Name _____ Phone # _____

Spouse's name _____

Employer _____

Address _____

Occupation _____

Work # _____ Ext _____ Birth date ___/___/___

For new patients, whom may
we thank for referring you? _____

Other family members seen by us? _____

Previous/Present Dentist _____

Last visit to his/her office _____

What would you like us to do today? (for new patients)

_____

_____

Are you in dental discomfort? YES NO

Do you require antibiotics before dental treatment? YES NO

Have you ever had a serious or difficult problem with previous dental work? YES NO

Do you now or have you experienced pain in your jaw joints (TMJ)? YES NO

My current DENTAL health is ❑ Good ❑ Fair ❑ Poor

Are you allergic to any of the following?

Penicillin	Y N	Tetracycline	Y N	Latex	Y N
Aspirin	Y N	Dental Anesthetic	Y N	Metals	Y N
Erythromycin	Y N	Codeine	Y N	Other _____	

Do you smoke/chew tobacco? YES NO How much? _____

My current MEDICAL health is ❑ Good ❑ Fair ❑ Poor

Name of your physician _____

Please list all prescription and over the counter drugs you take:

_____

_____

Have you ever had the following?

Y	N	Heart Attack	Y	N	Drug Dependancy
Y	N	Stroke	Y	N	Alcohol Dependancy
Y	N	Cancer/Chemotherapy	Y	N	Hemophilia/Bleeding
Y	N	Heart Murmur	Y	N	Ulcers
Y	N	Rheumatic Fever	Y	N	Colitis
Y	N	HIV+/Aids	Y	N	Heart Defect
Y	N	Heart Surgery/Pacemaker	Y	N	Anemia
Y	N	Shingles	Y	N	Radiation Treatment
Y	N	Mitral Valve Prolapse	Y	N	Asthma
Y	N	Kidney Problems	Y	N	Arthritis
Y	N	Artificial Joints	Y	N	Difficulty Breathing
Y	N	Artificial Valves	Y	N	Hospitalized in last 5 years
Y	N	Sinus Problems	Y	N	Hepatitis A / B / C / Other
Y	N	High Blood Pressure	Y	N	Blood Transfusion
Y	N	Low Blood Pressure	Y	N	Emphysema
Y	N	Fever Blisters/Cold Sores	Y	N	Glaucoma
Y	N	Severe/Frequent Headaches	Y	N	Bisphosphonate
Y	N	Psychiatric Problems			Medications
Y	N	Epilepsy/Seizures			(ex. Fosomax, Boniva)
Y	N	Fainting	Y	N	Angina
Y	N	Diabetes Type I	Y	N	Liver Problems
Y	N	Diabetes Type II	Y	N	Thyroid Problems
Y	N	Tuberculosis	Y	N	Steroid Medications

For Women: Are you using birth control medication? YES NO

What type? _____

Are you pregnant? YES NO

How many weeks? _____

Are you nursing? YES NO

Payment Policy

Please be prepared to pay at the time of your visit. You may use cash, check, or credit cards. We do charge a finance fee of 2% per month to all unpaid accounts over 30 days. If you have dental insurance we will work with you to obtain your maximum benefits. Please provide us with the necessary insurance information so we may submit for you.

Person financially responsible for treatment.

❑ SELF ❑ OTHER _____
NAME RELATIONSHIP PHONE NUMBERS

Primary Dental Insurance

Ins. Co. _____

Ins. Co. Address _____

Insured's Name _____

Relationship to pt. _____

Insured's Birthday _____

ID# _____ Group # _____

Insured's Employer _____

Secondary Dental Insurance

Ins. Co. _____

Ins. Co. Address _____

Insured's Name _____

Relationship to pt. _____

Insured's Birthday _____

ID# _____ Group # _____

Insured's Employer _____

I understand that the information that I have given is correct to the best of my knowledge.
I authorize the release of any information to my insurance company.

Signed: _____
PATIENT OR GUARDIAN

The information on these pages is true to the best of my knowledge.The undersigned authorizes the dental staff or doctor to take x-rays, study models, photographs or other diagnostic materials deemed appropriate by the doctor to make a thorough diagnosis of my dental health. I authorize the doctor to perform any and all forms of treatment, medication, and therapy which may be indicated in connection with the services required for my dental health. I understand that the doctor will discuss treatment before beginning. I further authorize and consent that the doctor choose and employ such assistance as deemed fit.

Signed: _____ Date: _____
PATIENT OR GUARDIAN

Signed: _____ Updated: _____
PATIENT OR GUARDIAN

Signed: _____ Updated: _____
PATIENT OR GUARDIAN

_____

_____

_____

_____

_____

Reviewed by: _____ Date: _____