WELCOME

TO THE OFFICE OF DAVID P. BROCK, D.M.D., M.S.

PLEASE FILL OUT THIS FORM COMPLETELY

ABOUT YOU

E-Mail Address:________________________________

Name:______________________________________

I prefer to be called:___________________________

Birthdate:_________Age:_____SS#:________________

Home Address:_________________________________

____

☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Hm#:(___)___________Cell/Pager#:(___)____________

Wk#:(___)___________Ext:_____Dr Lic#:____________

Employer:_____________________________________

Employer's Address:______________________________

City:_________________State:______Zip:____________

How long there?_____Occupation:___________________

Best time & phone # to reach you?___________________

Whom may we thank for referring you?_______________

Other family member seen by us:____________________

Previous Dentist:_______________________________

Last Visit Date:____________Reason:_________________

Neighbor or Relative not living with you.

Name:_______________________Relation:____________

Wk#:(___)_________________Hm#:(___)____________

Address:_______________________________________

____

City State Zip

YOUR SPOUSE

Name:______________________________________

Employer:_____________________________________

Wk#:(___)______________Ext:____SS#:______________

Birthdate:_____________Dr. Lic#:__________________

INSURANCE

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name:________________________________

Insurance Co. Address:______________________________

Insurance Co. Phone #: (__)__________________________

Group # (Plan, Local or Policy #):______________________

Insured's Name:____________________Relation:___________

Insured's Birthdate:________Insured's SS#:________________

Insured's Employer:_________________________________

Employer's Address:_________________________________

Secondary Insurance

Insurance Co. Name:________________________________

Insurance Co. Address:______________________________

Insurance Co. Phone #: (__)__________________________

Group # (Plan, Local or Policy #):______________________

Insured's Name:____________________Relation:___________

Insured's Birthdate:________Insured's SS#:________________

Insured's Employer:_________________________________

Employer's Address:_________________________________

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to David P. Brock, D.M.D., M.S. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____

Responsible Party Signature

____________________________ ______________

Relationship Date

Please complete this section when the responsible party for the account is not listed on this form: Person Responsible___________________

Wk#:(___)______________Ext:____Hm#:(___)_________________

Relationship:_______________SS#:_______________________

MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name:________________________________

Address:____

Phone #:_________________Date of Last Visit:________

Your current physical health is: ☐Good ☐Fair ☐Poor

Are you currently under the care of a physician? ☐Yes ☐No

Please Explain:__________________________________

Do you smoke or use tobacco in any form? ☐Yes ☐No

Have you had any metal rods, pins or implants? ☐Yes ☐No

Are you taking any medications? ☐Yes ☐No

Please list each one:_________________________________

____

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding
Y N Alcohol/Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones/Joints/Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer /Chemotherapy
Y N Colitis

Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack/Surgery
Y N Heart Murmur
Y N Hemophilia

Y N Hepatitis
Y N Herpes / Fever Blisters
Y N High Blood Pressure
Y N Hospitalized for any reason
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Pacemaker

Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic/Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease/Trait
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

Please list any serious medical conditions that you have ever had:

____

Are you allergic to any of the following?

Y N Aspirin
Y N Codeine
Y N Latex
Y N Erythromycin
Y N Jewelry/Metals
Y N Dental Anesthetics
Y N Penicillin
Y N Tetracycline
Y N Other

Please list any other drugs/materials that you are allergic to:

____

For Women: Are you taking birth control pills? Y N Nursing: Y N

Are you Pregnant? Y N # of Weeks______

DENTAL HISTORY

Why have you come to the dentist today?__________

____

Have you ever taken bisphosphonates (i.e. fosomax)? Y N

Have you ever taken phen-phen or redux? Y N

Do you require Antibiotics before dental treatment? Y N

Are you currently in pain? Y N

Have you ever had a serious/difficult problem with any previous dental work? Y N

Have you ever had gum treatment? Y N

Do you now or have you ever experience pain/ discomfort in your jaw joint (TMJ/TMD)? Y N

Any unfavorable dental experiences? Y N

Are you happy with the color of your teeth? Y N

Your current dental health is: ☐Good ☐Fair ☐Poor

Do you like your smile? ☐ Y ☐ N

How many times do you: floss/week? _____

How many times do you: brush/day? _____

Are your teeth sensitive to heat, cold or anything else?

____

Have you lost any teeth? ☐ Y ☐ N

Notes:____

____

____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

______________________________ __________

Signature Date

I verbally reviewed the medical/dental information above with patient named herein.

Doctor's Initials:___________Date:___________

MEDICAL HISTORY UPDATES

Date:_________Comments:_____________________________________Initials:____

Date:_________Comments:_____________________________________Intials:____

Date:_________Comments:_____________________________________Initials:____

Date:_________Comments:_____________________________________Initials:____