David M. Briller, DMD PC
Family & Cosmetic Dentistry
P: 856-629-5522 F: 856-629-8361

Patient Information

Name: _____ Preferred Name: _____

Home Address: _____ City: _____ State _____ Zip: _____

Home #: _____ Mobile #: _____ Work #: _____

Email: _____

Would you like to receive text message/email reminders for your appointments? Y / N

Sex: M / F Birth Date: ___ /___ /_____ SS#:_____ Marital Status: _____

How did you hear about our office?_____

Person Responsible for Account

Name of responsible party: _____

Relationship to patient (Circle): Self Spouse Parent Other: _____

Home Address: _____ City: _____ State: _____Zip: _____

Home #: _____Work #: _____ Mobile #: _____

Birth Date: ___ /___ /_____ SS#:_____

Insurance Information (Primary)

Name of Insured:_____ DOB: ___ /___ /_____ Relation to Patient:_____

Insurance Company:_____ Employer:_____

Group #: _____ ID #: _____

Insurance Information (Secondary)

Name of Insured:_____ DOB: ___ /___ /_____ Relation to Patient:_____

Insurance Company:_____ Employer:_____

Group #: _____ ID #: _____

Health History

Conditions			Conditions			Conditions		
Y	N	Abnormal Bleeding	Y	N	Heart Attack	Y	N	Drug Abuse
Y	N	Alcohol Abuse	Y	N	Heart Surgery	Y	N	Seizures
Y	N	Allergies	Y	N	Hemophilia	Y	N	Sinus Problems
Y	N	Anemia	Y	N	Hepatitis	Y	N	Stroke
Y	N	Angina Pectoris	Y	N	High Blood Pressure	Y	N	Thyroid Problems
Y	N	Arthritis	Y	N	HIV+ AIDS	Y	N	Emphysema
Y	N	Artificial Bones	Y	N	Kidney Problems	Y	N	Epilepsy
Y	N	Artificial Heart Valve	Y	N	Liver Disease	Y	N	Fainting Spells
Y	N	Asthma	Y	N	Low Blood Pressure	Y	N	Fever Blisters
Y	N	Blood Transfusion	Y	N	Mitral Valve Prolapse	Y	N	Smoke/Tobacco
Y	N	Cancer- Chemotherapy	Y	N	Pace Maker	Y	N	Frequent Headaches
Y	N	Congenital Heart Defect	Y	N	Radiation Therapy	Y	N	Heart Murmur
Y	N	Cosmetic Surgery	Y	N	Rheumatic Fever	Y	N	Venereal Disease
Y	N	Diabetes	Y	N	Difficulty Breathing			

Primary Doctor:_____ Phone Number:_____

Women Only	Allergies			Allergies		
Are you currently Taking Birth Control? Y / N	Y	N	Aspirin	Y	N	Latex
Are you pregnant? Y / N If Yes, # of weeks? _____	Y	N	Codeine	Y	N	Metals
Are you nursing? Y / N	Y	N	Dental Anesthetics	Y	N	Penicillin
	Y	N	Erythromycin	Y	N	Tetracycline
	Y	N	Jewelry	Y	N	Other?

Please list any medications you are currently taking in the box below

Do you have any other conditions that have not covered above? Please describe below.

Patient/Guardian Signature: _____ Date:_____