



David M. Briller, DMD PC
Family & Cosmetic Dentistry
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Patient Information

Name: _____ Preferred Name: _____

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

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

Email: _____

When was your last dental visit? _____

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 (For Children or Power of Attorney)

Name of responsible party: _____

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

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

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

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

Dental Insurance Information (Primary)

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

Insurance Company: _____ Employer: _____

Group #: _____ ID #: _____

Dental Insurance Information (Secondary if Applicable)

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: _____

<u>Women Only (This Section)</u>
Are you currently Taking Birth Control? Y / N
Are you pregnant? Y / N If Yes, # of weeks? _____
Are you nursing? Y / N

<u>Allergies (Everyone)</u>	
Y N Aspirin	Y N Latex
Y N Codeine	Y N Metals
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: _____