

# Broken Arrow Family Dentistry \*\*\* 2011 \*\*\*

Thank You for Choosing Our Practice for Your Dental Care!

## PATIENT:

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

**Please Circle Your Preferred Method of Contact for Appointment Reminders (above).**

Birthdate: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Male \_\_\_ Female \_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

## RESPONSIBLE PARTY: Please complete any information that is different than that shown for the patient.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Male \_\_\_ Female \_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

## EMERGENCY CONTACT:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

**PRIMARY** Policy Holder Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Relationship: \_\_\_\_\_ SS#: \_\_\_\_\_ ID#: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Group #: \_\_\_\_\_ Group Name: \_\_\_\_\_

Insurance Co: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**SECOND** Policy Holder Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Relationship: \_\_\_\_\_ SS#: \_\_\_\_\_ ID#: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Group #: \_\_\_\_\_ Group Name: \_\_\_\_\_

Insurance Co: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**REFERRAL: Please tell us whom we may thank, or recognize for referring you to our practice.**

Name: \_\_\_\_\_ Phone Book: \_\_\_\_\_ Other: \_\_\_\_\_

**I have read the BAFD Financial Policy and agree to the terms therein, including paying the estimated patient's share at the time of service. I understand that a monthly service charge of 1½ % (18% annually) may be added to any balance not paid within 30 days.**

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

## CHILD' S MEDICAL HISTORY

Information you give is strictly confidential and will not be released to anyone without your written permission.

PHYSICIAN: \_\_\_\_\_

Date of Last Physical: \_\_\_\_\_

**DOES THE PATIENT CURRENTLY HAVE OR HAVE A HISTORY OF THE FOLLOWING:**

YES NO

_____	_____	Rheumatic Fever
_____	_____	Heart Disease
_____	_____	Diabetes
_____	_____	Asthma
_____	_____	Allergies
_____	_____	Kidney Disease
_____	_____	Hepatitis
_____	_____	Seizures
_____	_____	Toothache
_____	_____	Allergic Reaction to any medications

if yes, what \_\_\_\_\_

\_\_\_\_\_ IS THE PATIENT TAKING ANY DRUGS OR MEDICATIONS?

if yes, what \_\_\_\_\_

\_\_\_\_\_ IS THERE ANYTHING ELSE ABOUT THE PATIENTS HEALTH YOU FEEL WE SHOULD KNOW?

if yes, what \_\_\_\_\_

**PLEASE ANSWER THE FOLLOWING QUESTIONS REGARDING THE PATIENT'S DENTAL HISTORY:**

YES NO

_____	_____	First dental visit?
_____	_____	Currently have toothache now or any discomfort?
_____	_____	Nervous about this appointment?
_____	_____	Ever had a bad experience at a dental appointment?
_____	_____	Brush his/her own teeth?
_____	_____	Eat many sweets?
_____	_____	History of thumb or finger sucking?