Patient Information

Patient Name: _____ **Date:** _____
Last, First, MI — Preferred name

Sex: Male _____ Female _____ Family Status: Single ___ Married ___ Separated ___ Divorced ___

Birth Day: _____-_____-_____ Age: _____ Social Security Number: _____-_____-_____

Address: _____
Street — Apartment #

_____
City — State — Zip Code

E-mail Address: _____

Phone Numbers: Home: _____ **Work:** _____ **Ext:** _____**Cellular:** _____

Employer: _____ **Occupation:** _____

Spouse Name: _____ **Birth Day:** ____-____-____ **Age:** _____**Spouse Employer:** _____

Whom may we thank for referring you? _____

Former Dentist _____ **Date of last dental visit** _____ **Date of last Dental X-rays**_____

Insurance Information

Primary Insurance
Name of Insured: _____
Last — First — MI

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insured's Birth Date: ____-____-____ ID # _____-____-_____ Employer Name _____ Group #: _____

Insurance Plan Name and Address: _____

_____

Secondary Insurance
Name of Insured: _____
Last — First — MI

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insured's Birth Date: ____-____-____ ID #: _____-____-_____Employer Name _____ Group #: _____

Insurance Plan Name and Address: _____

I the undersigned certify that my dependents or myself have insurance coverage and assign benefit directly to Dr. Tomas G. de Bruin D.D.S.
I hereby authorize the doctor or staff to release any information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Signed _____ ***Date*** _____

Consent for Services

In order to control our cost and best serve our patients we have specific financial policies, which we adhere to.
For non-established emergency patients without insurance, payment is always required in full at time of service.
For established patients without insurance, payment is expected at time of service. Payment plans through outside financing are available.
For insurance patients: deductible, co-pays, and all estimated patient portion of cost is due at time of service.
We will be happy to bill insurance for you and assist you in working with your insurance company to receive payment. Although dental insurance is a benefit we do not base our treatment plan on what insurance will pay. Dr. de Bruin will let you know the best treatment plan for your overall dental health. Insurance companies vary in the amount of payments because they pay a percentage of claims, up to a yearly maximum amount based on individual usual and customary allowances that vary between employers and insurance companies. Any charges not covered by insurance are the personal responsibility of the patient.
If you need to reschedule or cancel an appointment we require 48 hours notice to avoid a charge.

I have read the above conditions of treatment and payment and agree to their content.

_____ **Date:** _____ **Relationship to Patient:**_____
Signature of patient, parent or guardian

de Bruin
DENTAL CENTER
Tomas G. de Bruin, DDS
Commitment to Excellence in Dentistry

Name: Preferred Name: Date of birth: Age:

List any Allergies (if none write N/A)

List all Surgeries (type and date)(if none write N/A)

List all Medications you are taking and for what purpose (if none write N/A)

Medical History (write yes or no)

Artificial joints	Surgical implants	Arthritis/Rheumatism
Anaphylaxis	Anemia	Abnormal Bleeding
Blood disease/disorder	Cancer (type)	Radiation treatments
Chemotherapy	Growths/tumors	Cortisone Treatments
Diabetes Type I or II	Glaucoma	Sinus problems
Hay fever	Headaches	Head injuries
Hard of Hearing	Fainting/Dizziness	Stroke (date?)
Heart attack	Heart disease	Heart murmur
Congenital Heart lesions	Heart valves	Pacemaker
High blood pressure	Stress	Mitral valve prolapse
Hemophilia	Herpes	Venereal disease
Aids/HIV	Hepatitis (type?)	Jaundice/Liver disease
Kidney disease	Epilepsy	Mental disorders
Nervous disorders	Psychiatric care	Fen-phen or Redux Use
Chemical dependency	Recreational Drugs (type?)	Drink alcohol

Rheumatic fever	Scarlet fever	Asthma
Respiratory disease	Cough (Persistent)	Shortness of breath
Tuberculosis	Stomach problems/Ulcers	Swollen glands
Swollen feet/ankles	Unexplained Weight loss	Pregnancy (due date?)
Sports (type?)		

Your current physical health: good, fair, poor

Are you under the care of a physician? If yes, explain:

Name and phone number of physician:

Dental History Form

What is the reason for your visit today?

Date of your last visit to the dentist? Last cleaning? Last Full Mouth X-rays?

What was done at your last dental visit?

Previous dentist's name? Phone number? Address, city and state?

How often do you have dental examinations? How often do you brush? Floss?

Do you have any dental problems now? If yes, please explain:

Are any of your teeth sensitive to: (write yes or no and area)

Hot: Cold: Sweets: Biting/Chewing:

Do you have stained/discolored teeth?

Do you get cold sores/fever blisters?

Do your gums ever bleed or hurt?

Have your parents experienced gum disease or tooth loss?

Have you noticed any loose teeth or changes in your bite?

Do you:

Clench or grind your teeth when awake?

Clench or grind your teeth when asleep?

Bite your lips or cheeks regularly?

Have tired jaws, especially in the AM?

Have congested/full/stuffy/itchy ears?

Have ringing in the ears?

Experience loss of balance/Vertigo?

Gag when taking dental x-rays?

Have difficulty swallowing?

Snore?

Sleep with someone who snores?

Breathe through your nose?

Breathe through your mouth?

Have sinus/allergy problems?

Smoke or chew tobacco?

Have you ever had: (write yes or no)

Your wisdom teeth removed?

Other oral surgery?

Orthodontics (braces)?

Your teeth extracted for ortho?

To wear headgear for ortho?

Periodontal (gum) treatment?

Your teeth ground or your bite adjusted?

A bite plate or mouthguard?

A serious injury to the head or neck?

If yes, please explain:

Have you experienced: (write yes/no)

Popping or clicking in your jaw joints?

Pain (ear, jaw joints, side of face)?

Difficulty opening or closing your mouth?

Headaches?

Neck aches?

Shoulder aches?

Back pain (upper, middle, lower)?

Hip pain?

Knee, ankle, foot pain?

Have you ever had a migraine?

How often?

Are you nervous about dental treatment?

What are your concerns?

Is there anything else about having dental treatment that you would like us to know?