CONFIDENTIAL PATIENT INFORMATION

Date_____

NAME_____, _____
Last First Middle

Current Address_____

City_____State_____Zip_____

Permanent Address (if different from above) _____

City_____State_____Zip_____

Email address_____ Home Phone (____) _____Cell Phone (____) _____

Place of Employment _____Occupation_____

Work Address _____Work Phone ( )_____

Preferred Method of Contact_____

Date of Birth _____ SS# _____Male _____ Female _____

Height ___ ft. ___ in. Weight _____lbs. Marital Status: Single Married Divorced Widowed

Hobbies: _____

Person Responsible for Payment of Account:

Self _____Guarantor _____Relationship_____Guarantor's Occupation_____

SPOUSE NAME _____Occupation_____

Address if different from above _____

City_____State_____Zip_____

Whom may we thank for referring you to our office? _____

Has any member of your family been treated in our office previously? Yes No Relationship_____

Why did you choose Dr. Strupp/Brumm as your dentist? _____

Reason for Visit: _____

DENTAL HEALTH: Please circle one: Excellent Good Fair Poor

What priority do you give your teeth (From 1-10 with 10 being the highest) 1 2 3 4 5 6 7 8 9 10

DENTAL INSURANCE:

PRIMARY Carrier Insurance Company _____

Mailing Address _____

Employee_____Member# _____ Group #_____

SECONDARY Carrier Insurance Company _____

Mailing Address _____

Employee_____Member# _____ Group #_____

MEDICAL HEALTH: Excellent Good Fair Poor

Physician's Name and contact information_____

Date of last complete physical: _____Are you under a doctor's care now? Yes No

If yes, for what reason? _____

Please list any medications, pills or drugs you are taking: _____

_____

_____

_____

Please list any vitamins or herbs you are taking: _____

Have you ever received a blood transfusion? Yes No When? _____

CONFIDENTIAL PATIENT INFORMATION

Are you pregnant? _____ Expected delivery date? _____
Are you subject to prolonged bleeding? Yes No Do you smoke? _____ How many packs per day? _____
Daily liquids you consume: _____Candy consumption per day: _____
Are you allergic to: Penicillin Codeine Latex Local Anesthetics (list which ones) _____
Other medications to which you are allergic: _____
Other allergies: _____

Please Circle If You Have or Have Had Any of the Following:

Heart Trouble	High Blood Pressure	Artificial Joints	Recent Unintentional Weight Loss
Heart Murmur	Low Blood Pressure	Stroke	Cancer _____
Rheumatic Fever	Diabetes	Ulcers	X-Ray or Cobalt Treatment
Congenital Heart Lesion	Blood Disease	Allergies	Chemotherapy/Radiation
Artificial Heart Valve	Hepatitis A B C	Asthma	Thyroid Disease/Parathyroid Disease
Heart Pacemaker	Liver Disease	Fainting or Dizziness	Arthritis/Gout
Heart Surgery	Anemia	Hay Fever	Glaucoma
Chest Pain	HIV Positive	Sinus Trouble	Epilepsy or Seizures
Mitral Valve Prolapse	Hypoglycemia	Emphysema	Alzheimer's Disease
Shortness of Breath	Hemophilia	Frequent Cough	Psychiatric Care
Swelling of Feet/Ankles/Hands	Kidney Trouble	Lung Disease	Acid Reflux

Have you ever had any other serious illness not checked above? Yes____ No____ If yes, or if you have any other conditions that could affect your dental treatment please describe in detail: _____
_____
_____

I will allow Drs. Strupp/Brumm to photograph/video record and use for educational or promotional purposes any aspect of my dental conditions or treatment procedures, and to publish such photographs/videos and any testimonials I provide. I further permit Drs. Strupp/Brumm to discuss my conditions/treatment with my physicians, referral doctors and other dental professionals either verbally or in writing by any means including but not limited to electronic transmission such as fax or non-encrypted email. They may also request any relevant medical information from my physicians they deem necessary for my dental treatment. Payment is due at the time of treatment. A finance charge of 18% per year will be added to any account that is delinquent and Patient and Guarantor shall be jointly and severally liable for all reasonable costs and expenses (including, without limitation, reasonable attorneys' fees) incurred by the Dental Practice in collecting any past due amounts. Payment is due when services are rendered unless other arrangements have been made.

ACKNOWLDEGED AND ACCEPTED BY:
Patient's Signature _____
Print Name: _____
Guarantor's Signature_____
Print Name_____

MEDICAL UPDATES

Date: _____
Date: _____
Date: _____