RICHARD T. BRUCE, D.D.S.

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Thank you for choosing our office as your Dental care team.
We strive to provide you with the best possible dental care.
In order for us to meet all of your healthcare needs please fill out this form completely. If you have any questions or need assistance, please ask. We are happy to assist you!

PATIENT INFORMATION

Name _____ Date of Birth _____

Address _____

Social Security Number _____

Cell Phone Number _____ Home Phone Number _____

Email _____

Marital status (circle): Single Married Divorced Widow

Person to contact in case of emergency _____ Relation _____
Phone# _____

What is the primary purpose of your visit? _____

RESPONSIBLE PARTY

Name of person responsible for this account _____

Relationship to patient _____

Address _____

Email _____

Birthdate _____ Employer _____ Social Security Number _____

Work phone number _____

INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient_____
Birth date _____
Name of Employer_____
Address of employer _____Cit:_____ State_____
Zip_____
Insurance Company _____ Group#:_____
Policy/ID #_____ Insurance Company phone #_____

SECONDARY INSURANCE

If you have secondary insurance please complete.

Name of Insured_____ Relationship to Patient_____
Birth date_____
Name of Employer_____
Address of employer _____City _____State _____
Zip_____
Insurance Company_____ Group# _____ Policy/ID#:_____
Insurance Company phone #_____

HEALTH QUESTIONNAIRE

Physician:_____ Office Phone:_____ Date of Last Exam:_____

1. Are you under any medical treatment now?
*If Yes, please explain.*_____

2. Have you ever been hospitalized for any surgical operation or serious illness for the last five years?
If yes, please explain.
_____

3. ***Allergies and Medication:***
Are you allergic to:

	Yes	No		
Penicillin/Antibiotics				
Barbiturates				
Iodine				
Metals (nickel, mercury)				
Sulfa Drugs				
Sedatives				
Aspirin				
Latex				
Other (list)				

4. Are you taking any medications including **NON** prescription medications? Y/N

If yes, what medications are you taking?
List current medications here:

5. Do you have a persistent cough NOT associated with a known illness lasting more than 3 weeks? Y/N

6. Have you ever taken Fosamax, Boniva, Actonel, Or any Cancer medication containing Bisphosphonate? Y/N

7. Have you taken Viagra? Revati, Cialis or Levitra? In the last 24 hours? Y/N

8. Do you use Tobacco? Y/N
If **Yes**, how often?_____

9. Do you use controlled substances? Y/N
If **Yes**, which ones and how often? _____

Do you have ***or*** have you had any of the following?

	Y	N		Y	N		Y	N
Heart Trouble			Respiratory Problems			Diabetes		
High Blood Pressure			COPD/Emphysema			Kidney Disease		
Heart Attack			Asthma			Anemia		
Mitral Valve Prolapse			Tuberculosis			Cancer		
Swollen Ankles			Snoring			Radiation Therapy		
Heart Disease			Frequently Tired			Recent Weight loss		
Cardiac Pacemaker			Thyroid Problems			AIDS/HIV Infection		
Heart Murmur			Fainting/Lightheadedness			Stroke		
Angina			Epilepsy/Seizures			Glaucoma		
Chest Pains			Arthritis			Stomach Troubles/Ulcers		
Easily Winded			Joint Replacement/Implant			Hay Fever/Allergies		
Low Blood Pressure			Liver Disease			STD's		
Rheumatic Fever			Hepatitis/Jaundice			Other:		

WOMEN ONLY
Are you pregnant or thinking of becoming pregnant? Y/N
Are you nursing? Y/N
Are you taking oral contraceptives Y/N

PATIENT DENTAL HISTORY

Name of previous dental provider

_____

*Date of last exam*_____

1. *Do your gums bleed while brushing or flossing?* Y/N
2. *Are your teeth sensitive to hot or cold liquids/food?* Y/N
3. *Are your teeth sensitive to sweet or sour liquids/food?* Y/N
4. *Do you feel pain to any of your teeth?* Y/N
5. *Do you have any sores or lumps in or near your mouth?* Y/N
6. *Do you have frequent headaches?* Y/N
7. *Do you clench or grind your teeth?* Y/N
8. *Do you bite your lips or cheeks frequently?* Y/N
9. *Have you ever had any difficult extractions in the past?* Y/N
10. *Have you ever had any prolonged bleeding following extractions?* Y/N
11. *Have you had any orthodontic treatment?* Y/N
12. *Do you wear dentures or partials? If Yes, date of placement?* Y/N

*If yes, date:*_____

13. *Have you ever received oral hygiene instructions regarding the care of your teeth and gums?* Y/N
14. *Have you had any head, neck, or jaw injuries?* Y/N
15. *Have you ever experienced problems in your jaw?*
    - *Clicking* Y/N
    - *Pain (joint, ear, side of face)* Y/N
    - *Difficulty opening or closing?* Y/N
    - *Difficulty in chewing?* Y/N
16. *Do you like your smile?* Y/N

AUTHORIZATION AND RELEASE

I certify that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ _____

Signature of patient (or parent/guardian if minor) *Date*

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

_____ _____

Print Patient's Name **Date**

I acknowledge that I have received a copy of this office's NOTICE OF PRIVACY PRACTICES or that this office's NOTICE OF PRIVACY PRACTICES was made available to me to receive.

_____

(signature of patient/parent/legal guardian)

I consent to the use and disclosure of my personal health information by your office for treatment, billing/payment and healthcare operations as outlined in the NOTICE OF PRIVACY PRACTICES.

_____

(signature of patient/parent/legal guardian)

I Authorize MB Dentist to disclose health information

_____

(signature of patient/parent/legal guardian)

____ All of my health information.
____ My health information related to the following treatment or condition:_____
____ My health information covering the time period between _____ and _____.

To:Person(s)
Name_____ Relation:_____ Phone Number:_____
Name_____ Relation: _____ Phone Number:_____

____ None of my health information is to be shared to another person.

INSURANCE INFORMATION

We are a Fee for Service Provider. That means that we do not participate with any insurance company. You are responsible to pay at the time services are rendered. We will gladly submit your insurance claim for you, and they will reimburse you according to your plan. If you have any questions about your insurance, you can always contact your dental insurance company. We are more than happy to answer any questions you may have.