BRECKENRIDGE DENTAL GROUP

PATIENT HISTORY & INFORMATION

Welcome to our office. We are pleased to have the opportunity to treat your dental needs. Please fill out the information on this page for our records.

Patient Name: _____ Today's Date: _____
Preferred Name: _____ Birth Date: _____
Mailing Address: _____ Age: _____ Sex: F M
City: _____ State: _____ Zip: _____ Marital Status: (circle one)
Physical Address: _____ Single Married Child
City: _____ State: _____ Zip: _____
Phone: (H): _____ (W): _____ (Cell): _____
Where and when are the best times to reach you? _____
Preferred appointment times: _____
Email: _____
Whom may we thank for referring you to our office? _____
Preferred Pharmacy: _____ Phone: _____
Employer: _____ Occupation: _____

Person Responsible for Payment: ___ Patient ___ Parent ___ Spouse Name: (if not Patient) _____
Does Patient have Dental Insurance Coverage? □ YES □ NO Name of Insurance Plan _____
Insured Member's Name: _____ Insured Member's Birth Date: _____
Insured Member's Social Security # OR Insurance Subscriber ID #: _____

Person to contact in case of emergency: _____
Relationship to Patient: _____ Phone: _____
□ Check here if same as Patient's address.
Address: _____ City: _____ State: _____ Zip: _____

Dental History Information

1. Would you like us to help you get your records transferred from your previous dental office? □ Yes □ No
   If Yes, please provide their contact information: _____
2. When was your last dental visit? _____ X-rays _____ Professional cleaning _____
3. Have you had regular dental checkups every 6-12 months? □ Yes □ No
4. How often do you have your teeth professionally cleaned? _____
5. Is it painful when your teeth are professionally cleaned? □ Yes □ No
6. Have you ever been treated for a gum (periodontal) problem? □ Yes □ No
   If Yes, what did you have done? _____ Date (Approx) _____
7. How often do you brush? _____ Floss? _____ Use mouth rinses? _____
8. Is it difficult for you to brush, floss or clean any area of your mouth? □ Yes □ No
9. Do you have a high sugar diet? □ Yes □ No
10. Do you use or want to use nitrous for your dental appointments or dental cleanings? □ Yes □ No
11. Obstacles I see to excellent dental health for myself. (check all that apply)
    □ No obstacles □ Time □ Fear of pain □ Cost □ Other
12. How do you feel about the appearance of your teeth? _____

13. These are the things that are important to me about my dental health: _____
14. Is there anything about dentistry and oral health that you have never had adequately answered? _____
_____
15. Have you had any trauma to your head, neck, mouth or teeth? □ Yes □ No
If Yes, please explain: _____
16. Have you had any clicking, popping or pain in your jaw joint? □ Yes □ No
17. Have you lost any teeth? □ Yes □ No Why? _____
18. Are you apprehensive about receiving dental treatment? □ Yes □ No
19. Have there been any complications during previous dental treatment? □ Yes □ No
20. Do you require antibiotics before dental treatment? □ Yes □ No
21. Is your water supply fluoridated? □ Yes □ No Does your water come from a well? □ Yes □ No

Do you have any of the following:

Yes	No		Yes	No	
□	□	Tooth pain	□	□	Bleeding or tender gums
□	□	Headaches, earaches, or neck pain	□	□	Unpleasant taste/bad breath
□	□	Teeth sensitive to hot, cold, sweets	□	□	Removable dentures
□	□	Teeth sensitive to pressure/chewing	□	□	Clicking or popping jaw
□	□	Food getting stuck between teeth	□	□	Difficulty opening or closing
□	□	Loose teeth	□	□	Clenching/grinding teeth
□	□	Cold sores/fever blisters	□	□	Bite splint or night guard

Do you have a specific problem not listed above that you would like us to evaluate? □ Yes □ No
If Yes, please explain: _____

Treatment Authorization and Financial Responsibility

I consent to necessary treatment for preventive dental care, for the diagnosis and treatment of dental disease, or desirable cosmetic dental care. In the case of a dental emergency, I consent to treatment as deemed necessary by the doctor, understanding that the procedures will be explained in advance. I give my consent for the use of local anesthetic for completing the necessary dental treatment. I also acknowledge full responsibility for the payment of such services and agree to pay for them, in full, **at the time of service**. I hereby authorize payment of my dental insurance benefits directly to Drs. Warner, Rehn, and Poulos. I understand that my dental benefits may be less than the actual bill for services and I understand that I am financially responsible for payments in full by signing this agreement. Accounts 30 days past due will accrue at 1.5% finance charge per month.

Signed: _____ Date: _____

Printed Name: _____

Notice of Privacy Practices Acknowledgment:

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Printed Name:_____

Signature:_____ Date:_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify) _____