Bradley M. Stewart DMD

Comprehensive Family Dentistry

Date: _____

Last Name:_____ First:_____ Middle:_____

What name would you like to use? _____ Sex (circle one): male female

Marital Status (circle one): Single Married Date of Birth: _____ Age: _____

Social Security #: _____

Address:_____City:_____ State:___ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email:_____ May we contact you through email? _____

Best time to contact:_____

Employer:_____City:_____State:____ Zip:_____

Occupation _____

Name of Spouse: _____ Spouse's Phone Number: _____

RESPONSIBLE PARTY (if other than patient) **PARENT'S NAME (if child)**

Name:_____ Relation to patient:_____

Address:_____City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone_____

Emergency Contact (<u>OTHER THAN SPOUSE</u>):

Name: _____

Relationship_____ Phone Number:_____

What is your reason for today's visit? _____

Is any other member of your family a patient in our practice? _____

How did you learn about our practice? ☐ Website ☐ Yellow pages ☐ Facebook ☐ Family

☐ Friend if so, their name_____

Are you under any medical treatment now? (I.e. chemo/radiation) If yes, explain.

_____

Have you had any major operations? (I.e. Bypass, joint replacements) If yes, explain.

_____

Have you had a serious accident involving head or jaw injuries? If yes, explain.

_____

Are you taking any blood thinners?

_____

Are you pregnant or breastfeeding? If pregnant, how far along are you?

_____

Please turn over to complete form

Do you have any of the following?

A.I.D.S/H.I.V. positive	____Yes ____No	Hearing Loss	____Yes ____No	Tumor or Growths	____Yes ____No
Bleeding Problems	____Yes ____No	Heart Ailment/Murmur	____Yes ____No	Venereal Disease	____Yes ____No
Blood Disease	____Yes ____No	High/Low Blood Pressure	____ Yes ____No	X-Ray Treatments	____ Yes ____No
Diabetes	____Yes ____No	Kidney Disease	____Yes ____No	Yellow Jaundice/Hepatitis	____Yes ____No
Do you smoke?	____Yes ____No	Liver Disease	____Yes ____No	Arthritis	____ Yes____No
Dry Mouth	____Yes ____No	Respiratory Disease	____Yes ____No		
Epilepsy	____Yes ____No	Sleep Apnea	____Yes ____No		
Fainting	____ Yes ____No	Stomach/Intestinal Disease	____Yes ____No		

Please list any allergies (drugs/food/latex gloves): _____

Have you ever had any adverse response to any drugs? _____

Are you currently taking any medications (Prescription or Non-Prescription): Please list: _____
_____

DENTAL HISTORY

Are you unhappy with the appearance of your teeth? ___ yes ___no
Would you like whiter teeth? ____ yes ___ no Have you had orthodontic treatment? ___ yes ___ no
Have you experienced any growth or sore spots in your mouth? ___ yes ___ no
Do your gums bleed? ___ yes ___ no
Do you have sleep or snoring issues? ___ yes ___ no
Have you ever had any periodontal (gum) treatment? ___ yes ____no
Do you clench or grind your teeth during the day or night? ___ yes ___ no
Do you have headaches, earaches, or neck pains? ___ yes ___ no
Are you apprehensive about your dental treatment? ___ yes ___ no
Any part of your mouth sore to pressures or irritants (cold, sweets, etc.)? ___yes ___no
If so, locate: _____

Previous Dentist: _____**Date of Last Visit:** _____

Family Physician: _____**Phone Number:** _____

FINANCIAL POLICY

Dental insurance is an agreement between you and your insurance company. Insurance only assists and does not relieve one of financial obligations. ***Please be advised we are not a preferred provider or in network with any insurance company other than Delta Dental (premier provider), Cigna (depending on individual plan), United Concordia (depending on individual plan), and Always Care.*** I hereby authorize payment of dental benefits directly to Dr. Bradley M. Stewart . I understand that I am responsible for all charges whether or not they are covered by insurance. The undersigned agrees to pay a collection fee of 33.33% of the total amount owed in the event the account is placed in the hands of or assigned to a third party for collection. The undersigned also agrees to pay all garnishment and/or court fees in the event of default. There will be a $30 service charge for all returned checks. All appointments not cancelled within 24 hours will be charge $25 and may increase with each occurrence.

CONSENT: The undersigned hereby authorizes Bradley M. Stewart DMD to take radiographs, study models, photographs, or any other diagnostic aids deemed necessary by Bradley M. Stewart DMD to make a thorough diagnosis of the patient's dental needs. I also authorize Bradley M. Stewart DMD to perform any and all forms of treatment, medication and therapy that may be indicated. All information on this page and the Medical History form is correct and fully understood by me. I understand the financial policy and also assign all insurance benefits, if applicable, to Bradley M. Stewart DMD.

Patient/Parent Signature : _____ **Date:** _____