THANK YOU FOR CHOOSING OUR OFFICE TO TAKE CARE OF YOUR DENTAL HEALTH.

YOU SHOULD FIND OUR STYLE OF DENTISTRY MUCH DIFFERENT THEN PAST DENTAL EXPERIENCES. DR BARRILLEAUX AND HIS STAFF ARE COMMITTED IN GIVING PERSONALIZED SERVICE WITH CUSTOMIZED DENTAL TREATMENT. TO THOSE PATIENTS WHO WANT MORE, WE WELCOME.

PATIENT INFORMATION

DATE :

(Prefers to be called)

NAME :_____ **LEGAL NAME :**_____

ADDRESS :_____

_____

*CITY :*_____ *STATE :*_____ *ZIP CODE :*_____

PHONE : *Home*_____ *Work*_____ *Cell*_____

- ***TO SUCCESSFULLY CONFIRM YOUR APPOINTMENTS, YOU CAN BE BEST REACHED AT :***

☐ *HOME* *TIME :*_____

☐ *WORK* *TIME :*_____

BIRTHDATE :_____ **AGE :**_____ **SEX :** ☐ *Male* ☐ *Female*

MARITAL STATIS : ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* **SPOUSES NAME :**_____

SOCIAL SECURITY NO. :_____-_____-_____

☐ **FULL TIME STUDENT ? WHERE :**_____

- **PERSON TO CONTACT IN CASE OF EMERGENCY :** NAME _____

(CLOSEST RELATIVE NOT LIVING WITH YOU) PHONE _____

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE :

☐ *None* ☐ *Self* ☐ *Spouses* ☐ *Childs* ☐ *Other*

*EMPLOYED BY :*_____

*LOCATION :*_____

*INSURANCE CO. :*_____

- ***Complete if insured is DIFFERENT from patient.***

INSURED NAME :_____

INSURED DOB :_____/_____/_____

INSURED SSN :_____-_____-_____

SECONDARY DENTAL INSURANCE :

☐ *None* ☐ *Self* ☐ *Spouses* ☐ *Childs* ☐ *Other*

*EMPLOYED BY :*_____

*LOCATION :*_____

*INSURANCE CO. :*_____

- ***Complete if insured is DIFFERENT from patient.***

INSURED NAME :_____

INSURED DOB :_____/_____/_____

INSURED SSN :_____-_____-_____

- *If no insurance, please fill out place of employment.*

ACCOUNT INFORMATION

- ***RESPONSIBLE PERSON FOR PAYMENT :***

(COMPLETE IF OTHER THAN SELF)

*NAME :*_____

*ADDRESS :*_____

_____

*CITY :*_____ *STATE :*_____ *ZIP :*_____

*DRIVERS LICIENCE # :*_____

To verify account information and patient identification for medication prescriptions. Please allow the Patient Manager to make copies of your dental insurance card and drivers license.

PATIENT NAME	DATE

DENTAL & MEDICAL HISTORY

So that we may provide you with the best possible care please complete both Medical and Dental history sections below.
ALL INFORMATION IS COMPLETELY CONFIDENTIAL.

DENTAL HISTORY

(PLEASE CIRCLE)

DO YOU HAVE A SPECIFIC DENTAL PROBLEM ? *DESCRIBE* : _____ YES NO

DO YOU HAVE DENTAL EXAMINATIONS ON A ROUTINE BASIS? LAST VISIT : _____ YES NO

DATE OF LAST FULL MOUTH X-RAYS (16 SMALL FILMS OR PANORAMIC) : _____ YES NO

DO YOU THINK YOU HAVE ACTIVE DECAY OR GUM DISEASE : _____ YES NO

DO YOU BRUSH AND FLOSS ON A ROUTINE BASIS? HOW OFTEN? : _____ YES NO

DO YOUR GUMS EVER BLEED? DESCRIBE:_____ YES NO

HAVE YOU NOTICED ANY MOUTH ODORS OR BAD TASTE? : _____ YES NO

DOES FOOD CATCH BETWEEN YOUR TEETH?_____ YES NO ANY LOOSE TEETH? : _____ YES NO

DO YOU EVER HAVE CLICKING, POPPING OR DISCOMFORT IN THE JAW JOINT?_____ YES NO

DO YOU BRUX OR GRIND YOUR TEETH? : _____ YES NO

DO YOU SMOKE OR CHEW TOBACCO? ANY SORES OR GROWTHS IN YOUR MOUTH? : _____ YES NO

DO YOU WANT TO KEEP YOUR REMAINING TEETH? : _____ YES NO

NAME OF PREVIOUS DENTIST (OPTIONAL) :_____

MEDICAL HISTORY

(PLEASE CIRCLE)

ARE YOU UNDER A PHYSICIAN'S CARE NOW ? *WHY* ? _____ YES NO

PHYSICIAN'S NAME : _____ PHONE : _____

HAVE YOU EVER BEEN HOSPITALIZED OR HAD A MAJOR OPERATION ? *DISCUSS*_____ YES NO

HAVE YOU EVER HAD A SERIOUS INJURY TO YOUR HEAD OR NECK ? *DISCUSS*_____ YES NO

ARE YOU TAKING ANY MEDICATIONS , PILL OR DRUGS ? *WHAT* ? _____ YES NO

EVER TAKEN ANY FEN-PHEN ? _____ YES NO

ARE YOU ON A SPECIAL DIET ? *DISCUSS*_____ YES NO

ARE YOU ALLERGIC TO ANY MEDICATIONS OR SUBSTANCES ? (PLEASE CHECK APPROPRIATE BOXES)

☐ ASPIRIN ☐ PENICILLIN ☐ CODEINE ☐ ACRYLIC ☐ METAL ☐ LATEX RUBBER ☐ OTHER _____

WOMEN (PLEASE CHECK) ☐ PREGNANT OR TRYING ☐ NURSING ☐ TAKING ORAL CONTRACEPTIVES

- DO YOU NOW HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING ? (PLEASE CIRCLE YES OR NO)

ARTIFICIAL JOINTS* YES NO	LIVER DISEASE YES NO	LEUKEMIA YES NO	RENAL DIALYSIS YES NO
HEART MURMUR* YES NO	HEPATITIS A INFECTIOUS YES NO	BLOOD TRANSFUSION YES NO	THYROID DISEASE YES NO
MITRAL VALVE PROLAPSE* YES NO	HEPATITIS B OR C YES NO	SWELLING OF LIMBS YES NO	PARATHYROID DISEASE YES NO
RHEUMATIC FEVER* YES NO	VENEREAL DISEASE YES NO	LUNG DISEASE YES NO	ARTHRITIS/GOUT YES NO
ARTIFICIAL HEART VALVE* YES NO	AIDS YES NO	BREATHING PROBLEM YES NO	RHEUMATISM YES NO
HEART PACE MAKER* YES NO	HIV POSITIVE YES NO	SHORTNESS OF BREATH YES NO	CORTISONE MEDICINE YES NO
HEART TROUBLE/DISEASE YES NO	STROKE YES NO	FREQUENT COUGH YES NO	GENITAL HERPES YES NO
ANGINA/CHEST PAIN YES NO	EPILEPSY OR SEIZURES YES NO	HAY FEVER YES NO	DRUG ADDICTION YES NO
HEART ATTACK/FAILURE YES NO	PSYCHIATRIC CARE YES NO	SINUS TROUBLE YES NO	TATTOOS YES NO
COUMADIN YES NO	ALZHEIMER'S DISEASE YES NO	BLOODY SPUTUM YES NO	COLD SORES YES NO
DAILY ASPIRIN YES NO	*LATEX SENSITIVITY YES NO	CANCER YES NO	FEVER BLISTERS YES NO
HIGH BLOOD PRESSURE YES NO	SCARLET FEVER YES NO	CHEMOTHERAPY YES NO	HERPES YES NO
ANEMIA YES NO	IRREGULAR HEART BEAT YES NO	STOMACH DISEASE YES NO	CONVULSIONS YES NO
HEMOPHILIA/BLOOD YES NO	CONGENITAL HEART DISORD. YES NO	INTESTINAL DISEASE YES NO	FAINTING OR DIZZINESS YES NO
ASTHMA YES NO	HEART SURGERY YES NO	ULCERS YES NO	GLAUCOMA YES NO
EMPHYSEMA YES NO	LOW BLOOD PRESSURE YES NO	RECENT WEIGHT LOSS YES NO	TUMORS OR GROWTHS YES NO
TUBERCULOSIS YES NO	BLOOD DISEASE YES NO	FREQUENT DIARRHEA YES NO	NERVOUSNESS YES NO
RADIATION TREATMENT YES NO	UNEXPLAINED FEVER YES NO	EXCESSIVE THIRST YES NO	ALLERGIES (MEDICINES) YES NO
DIABETES YES NO	BRUISE EASILY YES NO	NIGHT SWEATS YES NO	ALLERGIES (POLLEN,DUST) YES NO
HYPOGLYCEMIA YES NO	EXCESSIVE BLEEDING YES NO	YELLOW JAUNDICE YES NO	HIVES OR RASH YES NO