Welcome to Bruner Dental Center

Please fill out this form completely; it is important to your care.

ABOUT YOU

Today's Date: _____ Married Single Partnered Divorced Separated Widowed

Name: _____ M/F Birthday ____/____/____ Age:____ SS #:_____
LAST FIRST MI

Home Address: _____
CITY STATE ZIP

Hm #:(____)_____ Cell #:(____)_____ Wk #:(____)_____ DL #:_____

E-Mail Address:_____ When are the best times to reach you?_____

Whom may we thank for referring you?_____ Other family members seen by us: _____

Employer:_____ How long there?_____ Occupation _____

Employer's Address:_____
CITY STATE ZIP

General Doctor:_____ Previous or Present (Please circle) Date of last visit:_____

In the event of an emergency, whom should we contact?

His/Her Name:_____ Relation:_____ Wk #:(_____)_____

Hm #:(_____)_____ Address:_____
CITY STATE ZIP

SPOUSE INFORMATION

His/Her Name: _____ Birthdate:____/____/____ SS #:_____

Employer:_____ Wk #:(_____)_____ DL #:_____

Person Responsible for Account, if other than yourself

Name: _____ Relation:_____ SS #:_____

Employer:_____ Wk #:(_____)_____ DL #:_____

Hm #:(_____)_____ Billing Address:_____

INSURANCE INFORMATION

Primary Insurance Dental Coverage: Yes/No Medical Coverage: Yes/No Orthodontic Coverage: Yes/No

Ins. Co. Name:_____ Ins. Co. Ph. #:(_____)_____ Group #(Plan, Local or Policy #:_____

Ins. Co. Address:_____
CITY STATE ZIP

Insured's Name:_____ Relation:_____ Insured's Birthdate:____/____/____ SS #:_____

Insured's Employer:_____ Employer's Address:_____
CITY STATE ZIP

Secondary Insurance Dental Coverage: Yes/No Medical Coverage: Yes/No Orthodontic Coverage: Yes/No

Ins. Co. Name:_____ Ins. Co. Ph. #:(_____)_____ Group #(Plan, Local or Policy #:_____

Ins. Co. Address:_____
CITY STATE ZIP

Insured's Name:_____ Relation:_____ Insured's Birthdate:____/____/____ SS #:_____

Insured's Employer:_____ Employer's Address:_____
CITY STATE ZIP

HISTORY

Do you have a personal physician (family doctor)? Yes / No
Physician's Name:_____
Address:_____
Phone #:(____)_____Date of last visit:_____
Your current physical health is: Good Fair Poor
Are you currently under the care of a physician? Yes / No
Please explain:_____
Do you smoke or use tobacco in any form? Yes / No

Are you allergic to any of the following?

Y / N Aspirin
Y / N Barbiturates
Y / N Codeine
Y / N Dental Anesthetics
Y / N Erythromycin
Y / N Jewelry/Metals
Y / N Latex
Y / N Penicillin
Y / N Sedatives
Y / N Sulfa Drugs
Y / N Tetracycline
Y / N Other

Please list additional drugs/materials that cause allergic reactions: _____

_____

_____

Are you taking any of the following:

Y / N Acetaminophen
Y / N Antibiotics
Y / N Antihistamines
Y / N Aspirin
Y / N Blood Thinners
Y / N Blood Pressure Medication
Y / N Cold Remedies
Y / N Digitalis/Heart Medication
Y / N Insulin/Diabetes Drugs
Y / N Nitroglycerin
Y / N Recreational Drugs
Y / N Steroids/Cortisone
Y / N Thyroid Medicine
Y / N Tranquilizers

Are you currently taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above? Yes / No
If yes, please list each one_____

_____

_____

Do you need pre-medicated before dental work? Yes/No
Are you pregnant? Unsure / Yes / No Week #:_____

WOMEN: Are you taking birth control pills? Yes / No
Are you nursing? Yes / No

Have you ever had any of the following diseases or medical problems?

Y / N Abnormal Bleeding
Y / N Alcohol Abuse
Y / N Anemia
Y / N Arthritis
Y / N Artificial Bones/Joints
Y / N Artificial Valves
Y / N Asthma
Y / N Blood Transfusion
Y / N Cancer
Y / N Chemotherapy
Y / N Chicken Pox
Y / N Colitis
Y/ N Congenital Heart Defect
Y / N Diabetes
Y / N Difficulty Breath
Y / N Drug Abuse
Y / N Emphysema
Y / N Epilepsy
Y / N Fainting Spells
Y / N Fever Blisters
Y / N Glaucoma
Y / N Hay Fever
Y / N Headaches
Y / N Heart Attack
Y / N Heart Murmur
Y / N Heart Surgery
Y / N Hemophilia
Y / N Hepatitis
Y / N Herpes
Y / N High Blood Pressure
Y/ N HIV+/AIDS
Y / N Hospitalized for Any reason
Y / N Kidney Problems
Y / N Liver Diseases
Y / N Low Blood Pressure
Y / N Lupus
Y / N Mitral Valve Prolapse
Y / N Osteoporosis
Y / N Pacemaker
Y / N Persistent Cough
Y / N Psychiatric Problems
Y / N Radiation Treatment
Y / N Rheumatic Fever
Y / N Scarlet Fever
Y / N Seizures
Y / N Shingles
Y / N Sickle Cell Disease
Y / N Sinus Problems
Y / N Steroid Therapy
Y / N Stroke
Y / N Thyroid Problems
Y / N Tonsillitis
Y / N Tuberculosis
Y / N Ulcers
Y / N Venereal Disease

CK'd By _____ (office use)

FINANCIAL RESPONSIBILTIES

I understand that I am responsible for services rendered and any service not covered by my insurance. I authorize the doctor to release all information necessary to secure payment of benefits. I authorize this signature on any insurance submission manual or electronic.

In consideration of the services to be provided to me, I hereby guarantee payment in full of my account in accordance with the financial arrangements made at the time of service. If no such arrangements are made or in the event of default in payment, reasonable collection agency fees equal to thirty percent of the delinquent balance shall be added to the amount due on the account, plus any applicable court costs or attorney fees.

I consent and agree that Bruner Dental and its affiliates may use any written electronic or verbal means to contact me on the phone number I provide by calling or texting, including use of an autodial program or by an artificial or pre-recorderd voice or by email address I provide. These calls, texts, or emails may be to deliver billing or account information, surveys or other business-related reasons. The provisions of services is not conditioned upon this consent and I undertand that I may revoke the consent at any time by providing a written notice.

PAYMENT IS DUE AT TIME OF SERVICE

_____ _____
SIGNATURE DATE

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.