BURKETT
FAMILY DENTISTRY

PATIENT INFORMATION

Name _____

Birthdate: _____Male / Female

SSN: _____

Address: _____

City: _____ St: _____ Zip: _____

Home Phone # ( ) _____

Cell Phone # ( ) _____*

*For patient's 18 or older

May we contact Patient via text: YES / NO

Work Phone # ( ) _____

E-mail _____

Minor Single Married Divorced Widowed Other

How did you hear about our practice?

RESPONSIBLE PARTY

Name _____

Birthdate: _____ Male / Female

SSN: _____

Address: _____

City: _____ St: _____ Zip: _____

Home Phone # ( ) _____

Cell Phone # ( ) _____

May we contact you via text: YES / NO

Work Phone # ( ) _____

E-mail _____

Relationship to patient:_____

EMERGENCY CONTACT

By listing a name below, you authorize Burkett Family Dentistry to disclose an emergency situation and to give a current status of the patient to the listed contact.

Name: _____ Relationship: _____

Main phone #: _____ Other #: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: Name of Insured: _____ DOB: _____

SSN: _____ Relationship to Patient: _____

Employer: _____ Phone #: ( ) _____

Insurance Company: _____ Phone#: ( ) _____

Insurance Address: _____

Group / Policy / Union/Local and/or ID #: _____

SECONDARY INSURANCE: Name of Insured: _____ DOB: _____

SSN: _____ Relationship to Patient: _____

Employer: _____ Phone #: ( ) _____

Insurance Company: _____ Phone#: ( ) _____

Insurance Address: _____

Group / Policy / Union/Local and/or ID #: _____

Patient Medical History for: _____ _____

Patient's Name ***Today's Date***

Your Current Physician: _____ Phone # _____
Name Location

Name of your previous Dentist _____ Date of last exam _____

Purpose of your initial visit with us _____

Are you aware of any dental problems _____

Do your gums bleed _____ Are you currently in pain _____

Are you under current medical treatment? ……	___	___
If so, for what _____		
Have you been hospitalized for any surgical operation or serious illness within the last 5 years? If so, please explain …….	___	___
_____		
Do you use tobacco? ……	___	___
Do you use controlled substances? ……..	___	___
Do you wear contact lenses? ……..	___	___
Are you taking any medications (including non-prescription) ***Please list below*** …	___	___
_____		
_____		

WOMEN ONLY:

Are you taking oral contraceptives? ……..	___	___
Are you now, or do you think you may be pregnant? ……	___	___
Are you currently nursing? ……	___	___

Are you allergic to or have you ever had a reaction to any of the following items:

	YES	NO
Anesthetics (Novacaine)…	____	____
Aspirin ……	____	____
Codeine ……	____	____
Darvocet ……....	____	____
Latex (Rubber) ……	____	____
Lortab ……	____	____
Metals (nickle, mecury) ….	____	____
Penicillin ……	____	____
Sedatives ……..	____	____
Sulfa Drugs ……..	____	____
OTHER: ……	____	____

_____

_____

Do you currently or have you ever had any of the following medical conditions?

	YES	NO		YES	NO		YES	NO
Anemia ……..	____	____	Heart Disease …….	____	____	Radiation Treatment ……..	____	____
Angina ……..	____	____	Heart Murmur ……..	____	____	Recent Weight Loss ……..	____	____
Arthritis ……..	____	____	Hepatitis …….....	____	____	Respiratory Problems …….	____	____
Asthma ……..	____	____	High Blood Pressure …..	____	____	Rheumatic Fever …….....	____	____
Bipolar ……....	____	____	HIV / AIDS …….....	____	____	S.T.D. ……	____	____
Blood Disorder ……..	____	____	Implant ……	____	____	Scarlet Fever …….....	____	____
Cancer / Tumors ……	____	____	Irregular Heartbeat …….	____	____	Seizures …….....	____	____
Chest Pains ……..	____	____	Jaundice ……..	____	____	Sinus Problems ……....	____	____
Diabetes ……	____	____	Joint Replacement …….	____	____	Stomach Problems …….	____	____
Dizziness ……....	____	____	Kidney Disease ……...	____	____	Stroke …….....	____	____
Easily Winded ……..	____	____	Leukemia …….	____	____	Swollen Ankles ……	____	____
Emphysema ……	____	____	Liver Disease ……..	____	____	Thyroid Problems ……	____	____
Epilepsy / Convulsions …..	____	____	Low Blood Pressure …..	____	____	Tuberculosis …….....	____	____
Fainting ……	____	____	Mental Disorder ……...	____	____	Ulcers ……	____	____
Glaucoma ……	____	____	Mitral Valve Prolapse ….	____	____	OTHER: _____		
Hay Fever ……	____	____	Pacemaker ……..	____	____	_____		
Head Injuries ……	____	____	**PRE-MED - Have you ever had or currently have to take a Pre-Med (antibiotic) prior to having dental work performed?** ……				____	____

AUTHORIZATION AND RELEASE

I certify that the above information I provided to be true to the best of my knowledge. I understand that providing incomplete or incorrect information can dramatically affect the type and manner of care Dr. Burkett and his staff provide me, my child(ren) / dependent(s). I also authorize Burkett Family Dentistry to release any medical, financial and personal information and / or records of any and all treatment, examinations, and diagnoses that have been rendered to myself, my child(ren) / dependent(s) by Burkett Family Dentistry. to third party payers, pharmacies, and /or other health care practitioners involved in providing care, support and financial assistance on behalf of myself, my child(ren) / dependent(s).

_____ _____

Signature of patient (or parent / guardian) Today's Date