

CONFIDENTIAL PATIENT INFORMATION

Dr. Lawrence S. Brannon
683 Berkmar Court
Charlottesville, VA 22901

Please complete **all** spaces on this form
Ask your receptionist for assistance, if necessary

Date: _____

PATIENT INFORMATION

Patient Name _____
Last First Middle Nickname

Address _____
Street City State Zip

Date of Birth _____ Sex M F Marital Status _____ SS# _____

Referred by _____ Home Phone _____

Person Responsible for Account: Name _____

Address: _____
Street City State Zip

Phone: _____ Social Security # _____

If Patient is a Minor — Parent(s) Name: _____
Last First Middle

Employer (Patient or Parent)
Name: _____
Company: _____
Address: _____
Phone: _____
Occupation: _____

Employer (Spouse or Parent)
Name: _____ SS# _____
Date of Birth: _____
Company: _____
Address: _____
Phone: _____
Occupation: _____

Dental Insurance Information
Ins. Company: _____
Address: _____
ID#: _____
Group or Policy #: _____
Is Ins. Primary Secondary?

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Ins. Company: _____
Address: _____
ID#: _____
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Is Ins. Primary Secondary?

Nearest relative not living with you: Name _____
Address: _____ Phone: _____

In case of Emergency, notify: Name _____
Address: _____ Phone: _____

This signature authorizes the practice to release dental information for insurance purposes. It also certifies that the information on this registration form is correct and that, if insured, the benefits are assigned directly to this practice. If I do not pay the entire new balance within 60 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of \$5.00) which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Signature of person responsible for account

Date

PATIENT INFORMATION

DENTAL HEALTH

When was your last dental visit? _____

How often did you see your dentist? _____

Are you having any dental problems that require immediate attention? _____

Do any of the following cause tooth discomfort? Hot _____ Cold _____ Sweets _____ Chewing _____

How often do you brush your teeth? _____ Floss? _____ Water Jet? _____

Do your gums bleed while cleaning? _____

Do your gums ever feel tender or swollen? _____

Have you had periodontal treatment? _____ When? _____

Do you clench or grind your teeth? _____

Do your jaws ever feel tired or ache? _____ Click or pop? _____

Can you chew on both sides of your mouth? _____ Comfortably? _____

Do you have frequent headaches? _____ Earaches? _____

Have you ever had orthodontic treatment (braces)? _____ When? _____

Have you had your "wisdom" teeth removed? _____ Any complications? _____

Do you lose fillings or break fillings? _____

Do you usually have many cavities? _____

Do you have any loose teeth? _____ Cracked or broken teeth? _____

Do you have any noticeable wear on your teeth? _____ Food traps? _____

Do you have any missing teeth? _____ Have they been replaced? _____

If so, how? Fixed bridge _____ Removable partial _____ Full denture _____ Dental implant _____

Are you comfortable with the replacement? _____ Please describe _____

How do you feel about the appearance of your smile? _____

Have you ever had any cosmetic dentistry done to improve your appearance? _____

If yes, are you pleased with the result? _____ Please comment _____

Have you ever had an unpleasant dental experience? _____

Please add anything you feel is important: _____

Signature _____

PATIENT NAME: _____

INITIAL DATE: _____

UPDATE: _____

UPDATE: _____

HEALTH INFORMATION

Personal Physician: _____
NAME ADDRESS

YES NO

- 1. Have you been hospitalized? For what? _____
- 2. Are you currently being treated by a physician? For what? _____
- 3. Are you currently taking any medicines or drugs? What? _____
- 4. Are you allergic to any drugs? What? _____
- 5. Are you allergic to any metals? What? _____
- 6. Have you ever had a skin rash or other reaction to metal jewelry? To what? _____
- 7. Do you bleed excessively upon injury?
- 8. Are you pregnant?

CIRCLE ANY OF THE FOLLOWING CONDITIONS WHICH YOU HAVE HAD

- A. AIDS/HIV Positive
- B. Arthritis
- C. Asthma
- D. Cancer
- E. Diabetes
- F. Epilepsy
- G. Glaucoma
- H. Heart Murmur
- I. Heart Problem
- J. Hepatitis
- K. High Blood Pressure
- L. Jaundice
- M. Kidney Problems
- N. Low Blood Pressure
- O. Rheumatic Fever
- P. Sexually Transmitted Diseases
- Q. Stroke
- R. Tuberculosis
- S. Other Diseases

If you circled either I or S describe conditions:

PERSON TO BE CONTACTED IN EMERGENCY (OTHER THAN RELATIVE)

NAME ADDRESS PHONE#

Signature: X	Reviewed by:	Date:
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