

PAUL W. BRITT, D.D.S.

1211 Wilmington Pike, Suite 306
West Chester, PA 19382

610-399-0864

Date _____
Name _____ Date of Birth _____
Address _____ Home Phone _____
City _____ State _____ Zip Code _____
Marital Status _____ Sex: Male Female
Spouse's or if minor, parent(s) or guardian(s) name _____
Person to contact in case of emergency _____ Phone _____
Employer _____ Business Phone _____
Do You Have Dental Insurance? Yes _____ No _____ Social Security Number _____
Who Referred You to Our Office? _____

Health History: Do you or have you ever had any of the following:

***DK - Means doesn't know.**

	Yes	No	DK
Do you wear a pacemaker?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or have you had any of the following?			
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint Replacement.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Disorders.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(Acquired Immune Deficiency Syndrome)			

***DK - Means doesn't know.**

	Yes	No	DK
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Radiation Treatment or Chemotherapy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver or Kidney Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug or Alcohol Dependency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there a possibility that you are pregnant?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking oral contraceptives?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you allergic to:			
Penicillin.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other antibiotics (Please specify _____).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine, aspirin.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Local anesthetic, Novocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (Please specify _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking any Herbal remedies, vitamins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What medications are you currently taking? _____

For what reasons? _____

Do you have any condition, disease or problem not listed above which we should know about? _____

What is the name, address & telephone number of your family physician?

What are the names, addresses and telephone numbers of any **specialists** who are treating you?

DENTAL HISTORY

Date of last examination _____ cleaning _____ x-rays _____

Name and address of previous dentist _____

Please indicate "yes" or "no" to the following questions.

Have you had gum disease or pyorrhea? _____

Any family history of gum disease? _____

Have you had periodontal treatment? _____

Do your gums bleed during brushing? _____

Are you subject to mouth ulcers or cold sores? _____

Do you clench or grind your teeth during the day or night? _____

Do you sometimes have pain in your jaw joint or your face? _____

Are your teeth sensitive to:

Pressure _____

Cold _____

Hot _____

Sweets _____

Have you had any head, neck or jaw injuries? _____

Does food catch between your teeth? _____

Have you experienced any unfavorable reaction to previous dental treatment? _____

Are you dissatisfied with the appearance of your teeth? _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

Signature _____ Date _____

The following spaces are left to be initialed and dated at future dental appointments, indicating that we have reviewed your answers on this form and that they are still correct.

Initials	Date	Initials	Date	Initials	Date
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

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Dental

Primary Insurance

Name of Insured _____

Employer's Name _____

Employer's Address _____

Name of Insurance Company _____

Address for claims: _____

City _____ State _____ Zip _____

Group # _____

Member ID

Policy I.D. # _____

Insured Social Security # _____

Insured Date of Birth _____

Secondary Insurance

Name of Insured _____

Employer's Name _____

Employer's Address _____

Name of Insurance Company _____

Address for claims: _____

City _____ State _____ Zip _____

Group # _____

Policy I.D. # _____

Insured Social Security # _____

Insured Date of Birth _____

Our office staff understands dental insurance. We will assist you in determining your allowed benefit. Your dental insurance is a contract between you and your employer, however, we will be happy to file your insurance claim as a courtesy to you.

I hereby authorize payment directly to Paul Britt D.D.S. of the group insurance benefits otherwise payable to me.



Signature

Date