Dr. Brough
FAMILY & COSMETIC DENTISTRY

CONFIDENTIAL

DATE_____

NAME_____BIRTHDATE_____ PHONE_____ CELL_____

ADDRESS_____CITY_____STATE_____ZIP_____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPERATED

PATIENT'S SOCIAL SECURITY #_____WHOM MAY WE THANK FOR REFERRING YOU_____

EMAIL ADDRESS_____ DO YOU PREFER CONTACT BY: ☐ CALL ☐ TEXT ☐ EMAIL

PATIENT'S EMPLOYER OR SCHOOL, IF STUDENT_____WORK PHONE_____

SPOUSE OR PARENT'S NAME_____EMPLOYER_____WORK PHONE_____

PERSON TO CONTACT IN CASE OF EMERGENCY_____PHONE_____

RESPONSIBILITY PARTY

PERSON RESPONSIBILITY FOR THIS ACCOUNT_____RELATIONSHIP TO PATIENT_____

ADDRESS_____HOME PHONE_____

DRIVER'S LICENSE #_____BIRTHDAY_____SOCIAL SECURITY #_____

EMPLOYER_____WORK PHONE_____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED_____RELATIONSHIP TO PATIENT_____

BIRTHDATE_____SOCIAL SECURITY #_____DATE EMPLOYED_____

NAME OF EMPLOYER_____WORK NUMBER_____

ADDRESS OF EMPLOYER_____CITY_____STATE_____ZIP_____

INSURANCE COMPANY_____GROUP #_____ID #_____

INSURANCE ADDRESS_____CITY_____STATE_____ZIP_____

DO YOU HAVE ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING INFORMATION

NAME OF INSURED_____RELATIONSHIP TO PATIENT_____

BIRTHDATE_____SOCIAL SECURITY #_____DATE EMPLOYED_____

NAME OF EMPLOYER_____WORK NUMBER_____

ADDRESS OF EMPLOYER_____CITY_____STATE_____ZIP_____

INSURANCE COMPANY_____GROUP #_____ID #_____

INSURANCE ADDRESS_____CITY_____STATE_____ZIP_____

PATIENT ACKNOWLEDGEMENT AND AUTHORITY

I, _____consent to treatment as necessary or desirable to the care of the patient name above, including but not restricted to whatever drugs, medication, performance of operations and conduct of laboratory, x-ray, or other studies that may be used by the doctor, or assistant, or qualified designate. I understand that during the course of the procedure(s), unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) than those set forth. I therefore authorize and request that Dr. Grant A Brough, D.D.S perform such procedures as are necessary and desirable in the exercise of professional judgment.

I understand that a perfect result is not guaranteed or warranted and cannot be guaranteed or warranted. I certify that I read and write English and have read and fully understood this consent. PLEASE ASK THE DOCTOR IF YOU HAVE ANY QUESTIONS CONCERNING THIS CONSENT FORM.

PATIENT MEDICAL HISTORY

PHYSICIAN_____OFFICE PHONE_____DATE OF LAST EXAM_____

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	☐	☐
3. ARE YOU TAKING ANY MEDICATIONS? IF YES, PLEASE LIST:	☐	☐
_____		
_____		
4. DO YOU USE TOBACCO?	☐	☐
5. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS?	☐	☐

6. ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTION TO THE FOLLOWING:

	YES	NO		YES	NO
LOCAL ANESTHETICS (ie. NOVACAINE)	☐	☐	PENICILLIN OR OTHER ANTIBIOTICS	☐	☐
ASPRIN	☐	☐	BARBITURATES	☐	☐
SEDATIVES	☐	☐	SULFA DRUGS	☐	☐
IODINE	☐	☐	OTHER _____		

7. ***WOMEN ONLY:***

	YES	NO
A) ARE YOU PREGNANT OR THINK YOU MAY BE?	☐	☐
B) ARE YOU NURSING?	☐	☐
C) ARE YOU TAKING BIRTH CONTROL?	☐	☐

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	HIGH BLOOD PRESSURE	☐	☐	HEART DISEASE	☐	☐	CHEST PAINS
☐	☐	HEART ATTACK	☐	☐	CARDIAC PACEMAKER	☐	☐	EASILY WINDED
☐	☐	RHEUMATIC FEVER	☐	☐	HEART MURMUR	☐	☐	STROKE
☐	☐	SWOLLEN ANKLES	☐	☐	ANGINA	☐	☐	HAY FEVER / ALLERGIES
☐	☐	FAINTING / SEIZURES	☐	☐	FREQUENTLY TIRED	☐	☐	TUBERCULOSIS
☐	☐	ASTHMA	☐	☐	ANEMIA	☐	☐	RADIATION THERAPY
☐	☐	LOW BLOOD PRESSURE	☐	☐	EMPHYSEMA	☐	☐	GLAUCOMA
☐	☐	EPILEPSY / CONVULSIONS	☐	☐	CANCER	☐	☐	RECENT WEIGHT LOSS
☐	☐	LEUKEMIA	☐	☐	ARTHRITIS	☐	☐	LIVER DISEASE
☐	☐	DIABETES	☐	☐	JOINT REPLACEMENT OR IMPLANT	☐	☐	HEART TROUBLE
☐	☐	KIDNEY DISEASES	☐	☐	HEPATITIS / JAUNDICE	☐	☐	RESPIRATORY PROBLEMS
☐	☐	AIDS OR HIV INFECTION	☐	☐	SEXUALLY TRANSMITTED DISEASE	☐	☐	OTHER_____
☐	☐	THYROID PROBLEMS	☐	☐	STOMACH TROUBLES / ULCERS			_____

COMMENTS

_____
_____
_____
_____
_____
_____
_____
_____

SIGNATURE OF DENTIST DATE

PATIENT DENTAL HISTORY

	YES	NO
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	☐	☐
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS / FOODS?	☐	☐
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS / FOODS?	☐	☐
4. DO YOU FEEL PAIN IN ANY OF YOUR TEETH?	☐	☐
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	☐	☐
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	☐	☐
7. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	☐	☐

	YES	NO
8. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
A) CLICKING?	☐	☐
B) PAIN (JOINT, EAR, SIDE OF FACE)?	☐	☐
C) DIFFICULTY IN OPENING OR CLOSING?	☐	☐
D) DIFFICULTY IN CHEWING?	☐	☐
9. DO YOU HAVE FREQUENT HEADACHES?	☐	☐
10. DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐

SIGNATURE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION, TO THE BEST OF MY KNOWLEDGE AND THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

X_____ _____

PATIENT, PARENT OR GUARDIAN DATE