TODAY'S DATE:______/______/______

WELCOME TO BROADMOOR DENTAL
WE ARE HERE TO CARE FOR YOU.
PLEASE LET US KNOW IF WE CAN ASSIST YOU IN ANY MANNER.

LAST NAME:____

FIRST NAME:____

MIDDLE INITIAL:__________ DATE OF BIRTH:________/_______/_______

MALE: [ ] FEMALE: [ ] SS#_____________/____________/____________

PARENT OR GUARDIAN:____

TELEPHONE: __________________________ CELL PHONE:____________________WORK PHONE:_________________________

OTHER CONTACT:_________________________E-MAIL ADDRESS:____

ADDRESS:____ CITY:____________________ STATE:___________ ZIP:__________

EMERGENCY CONTACT:____ TELEPHONE:________________________________

HOW CAN WE HELP YOU?

ARE YOU IN PAIN? _____________ WHERE (EXAMPLE: UPPER RIGHT TOOTH)?____

HAS ANYTHING YOU HAVE TRIED HELPED (EXAMPLE: PAIN PILLS)?____

ARE YOU INTERESTED IN IMPROVING THE APPEARANCE OF YOUR SMILE?____

WHAT WOULD YOU LIKE TO CHANGE ABOUT YOUR SMILE?____

HOW LONG HAS IT BEEN SINCE YOUR LAST CLEANING AND EXAM?____

DO YOU HAVE ANY SPECIFIC CONCERNS ABOUT YOUR TEETH OR DENTAL CARE?____

REWARDS!

THE PERSON WHO REFERRED YOU TO BROADMOOR DENTAL CARES FOR YOU AND WE WOULD LIKE TO SEND A GIFT OF APPRECIATION TO THEM. TO WHOM SHOULD WE SEND A GIFT? ____

ALTERNATIVELY, WHERE DID YOU HEAR ABOUT US: [ ] TELEVISION [ ] RADIO STATION________________________

[ ] NEWSPAPER (WHICH ONE?)_______________ [ ] OTHER____

WHEN YOU REFER A FRIEND TO US WHAT TYPE OF GIFT CARD WOULD YOU APPRECIATE?

[ ] STARBUCKS [ ] HOME DEPOT [ ] BORDERS [ ] BED-BATH & BEYOND [ ] GENESIS MEDSPA

PLEASE PRESENT YOUR INSURANCE CARD & INSURANCE INFORMATION SO THAT WE MAY ASSIST IN CLAIMS PROCESSING

	INSURANCE COMPANY	INSURNCE SUBSCRIBER LAST, FIRST, MIDDLE	RELATION TO PATIENT	HOLDER'S SOCIAL SECURITY #	HOLDER'S DATE OF BIRTH	PLAN, GROUP SUBSCRIBER NUMBERS
PRIMARY						
SECONDARY						

PRIMARY HOLDER INFORMATION IF DIFFERENT THAN PATIENT INFORMATION AT TOP OF PAGE:

Address:______________________________________ City:________________ State:______ Zip:________ Tele:___________________

Employer:_____________________________________ Occupation:______________ Work #:_________________

SECONDARY HOLDER INFORMATION IF DIFFERENT THAN PATIENT INFORMATION AT TOP OF PAGE:

Address:______________________________________ City:________________ State:______ Zip:________ Tele:___________________

Employer:_____________________________________ Occupation:______________ Work #:_________________

YOUR HEALTH HISTORY

LAST NAME________________________

FIRST NAME________________________

PHYSICIAN'S NAME:______________________________ LAST VISIT _______/_______/_______

Do you or have you pre-medicated for dental visits meaning have you been advised to take antibiotics prior to having dental care? ______ "Yes" , if so why?________________________ Or "No"______

Are you pregnant and if so enter due date: _________/_________/_________ Are You Nursing? _____ Yes/No

Health History Of The Following:	If "YES" are you being treated for the issue now & how?	Health History Of The Following:	If "YES" are you being treated for the issue now & how?
Anemia		Heart Attack	
Arthritis		Hemophilia	
Artificial Heart Valves		Hepatitis	
Artificial Joints		High Blood Pressure	
Asthma		HIV/AIDS	
Back Problems		Jaw Pain	
Blood Disease		Kidney Disease	
Cancer		Mitral Valve Prolapse	
Chemical Dependency		Neurologic Problems	
Chemotherapy		Pacemaker	
Circulatory Problems		Psychiatric Care	
Cortisone Treatments		Radiation Therapy	
Persistent Cough		Rheumatic Fever	
Diabetes		Scarlet Fever	
Epilepsy		Shortness of Breath	
Fainting		Stroke	
Glaucoma		Swollen Ankles	
Headaches		Thyroid Problems	
Heart Mumur		Tobacco Habit	
Heart Problems		Tuberculosis	

List All Medications You Are Presently Taking:	What Is The Medication Being Taken For?	How Often Are You Taking The Medication?

Do You Have Allergies To Medications or Have You Experienced Any Adverse Reactions to Any Dental or Medical Treatments?

Allergy or Reaction to:	When?	

Describe Any Other Medical Issues Or Surgeries:

To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any change in my health, or medications, or medical treatments I will inform the doctors at the next appointment without fail.

Printed Name:______________________ Date:__________ Parent/Guardian of:__________________

Signature:______________________

DOCTOR SIGNATURE:______________________