Patient Profile

The benefits of a happy, healthy smile are immeasurable. Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Patient Information

Date _____

Name _____

Email _____

I prefer to be called _____ ☐ Male ☐ Female

Birthday _____ Age _____ SS # _____

Home Address _____

☐ Single ☐ Divorced ☐ Separated

☐ Married ☐ Widowed ☐ Partner

Home Phone # _____ Cell # _____

Work Phone # _____ Extension _____

Employer _____

Employer Address _____

How long there? _____ Occupation _____

Best time to reach you? _____

Whom may we thank for referring you? _____

Other family member(s) seen by us? _____

Present/previous dentist? _____

Last visit date? _____

Emergency Contact

In the event of an emergency, is there someone who lives near you that we should contact?

Name _____ Relation _____

Physician _____ Phone # _____

Primary Insurance Coverage

Dental Coverage ☐ Yes ☐ No

Insurance Name _____

Address _____

_____

Phone _____

Group or Policy # _____

Insured's Name _____

Relation _____

Insured's Birthdate _____ Insured's ID # _____

Insured's Employer _____

Secondary Insurance Coverage

Dental Coverage ☐ Yes ☐ No

Insurance Name _____

Address _____

_____

Phone _____

Group or Policy # _____

Insured's Name _____

Relation _____

Insured's Birthdate _____ Insured's ID # _____

Insured's Employer _____

Payment

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. *Payment is due in full at the time of treatment unless prior arrangements have been approved.*

_____ _____

Signature Date

Insurance

If this office accepts insurance, I understand that I am responsible for payment of service rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I authorize the insurance payment to be made directly to this office. *Our office is HIPAA compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.*

_____ _____

Signature Date

Berchelmann FAMILY DENTAL

210.534.8051
608 Fair Ave
San Antonio, TX 78223

Patient History

Medical History

Do you have a primary physician? ☐ Yes ☐ No

Physician's Name _____

Phone # _____

Date of last visit _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

_____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription/over-the-counter or herbal supplement drugs? ☐ Yes ☐ No

Please list: _____

_____

Have you ever taken Fosamax or any other bisphosphonate?

☐ Yes ☐ No

For women: Are you using a prescribed method of birth control?

☐ Yes ☐ No

Are you pregnant?

☐ Yes, week # _____ ☐ No

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Yes	No		Yes	No	
☐	☐	Abnormal bleeding	☐	☐	Herpes/fever blisters
☐	☐	Alcohol/drug abuse	☐	☐	High blood pressure
☐	☐	Anemia	☐	☐	HIV/AIDS
☐	☐	Arthritis	☐	☐	Hospitalization
☐	☐	Artificial bones/joints/valves	☐	☐	Kidney problems
☐	☐	Asthma	☐	☐	Liver disease
☐	☐	Blood transfusion	☐	☐	Low blood pressure
☐	☐	Cancer/chemotherapy	☐	☐	Mitral valve prolapse
☐	☐	Colitis	☐	☐	Osteoporosis/osteopenia
☐	☐	Congenital heart defect	☐	☐	Pacemaker
☐	☐	Diabetes	☐	☐	Psychiatric treatment
☐	☐	Difficulty breathing	☐	☐	Radiation treatment
☐	☐	Emphysema	☐	☐	Rheumatic/scarlet fever
☐	☐	Epilepsy	☐	☐	Seizures
☐	☐	Fainting spells	☐	☐	Shingles
☐	☐	Frequent headaches	☐	☐	Sickle-cell disease/traits
☐	☐	Glaucoma	☐	☐	Sinus problems
☐	☐	Hay fever	☐	☐	Stroke
☐	☐	Heart attack	☐	☐	Thyroid problems
☐	☐	Heart murmur	☐	☐	Tuberculosis (TB)
☐	☐	Heart surgery	☐	☐	Ulcers
☐	☐	Hemophilia	☐	☐	Venereal disease
☐	☐	Hepatitis			

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Medical History

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Aspirin	☐	☐	Jewelry	☐	☐	Penicillin
☐	☐	Anesthetics	☐	☐	Latex	☐	☐	Tetracycline
☐	☐	Erythromycin	☐	☐	Metals	☐	☐	Sulfa

Please list any other drugs/materials you are allergic to:

_____

_____

Do you have or have you ever had any of the following?

Frequent, heavy snoring	☐ Yes	☐ No
Significant daytime drowsiness	☐ Yes	☐ No
Tendency to stop breathing while sleeping	☐ Yes	☐ No
Shortness of breath when waking up	☐ Yes	☐ No
Not feeling refreshed in the morning after sleep	☐ Yes	☐ No
Morning headaches	☐ Yes	☐ No

Dental History

Why have you come to the dentist today? _____

_____

Do you need antibiotics before dental treatment?	☐ Yes	☐ No	
Are you currently in pain?	☐ Yes	☐ No	
Do your gums ever bleed?	☐ Yes	☐ No	
Have you ever had a serious/difficult problem associated with any previous dental work?	☐ Yes	☐ No	
Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)?	☐ Yes	☐ No	
Your current dental health is:	☐ Good	☐ Fair	☐ Poor
Are you happy with your teeth?	☐ Yes	☐ No	

If not, please tell us why: _____

_____

Would you like whiter teeth? ☐ Yes ☐ No

How many times a week do you floss? _____

How many times a week do you brush? _____

Does food get stuck between your teeth? ☐ Yes ☐ No

If so, please describe where: _____

_____

What type of bristles do you use? ☐ Soft ☐ Medium ☐ Hard

Do you smoke or use tobacco in any form? ☐ Yes ☐ No