Barry D. Bracc, D.M.D. & Associates, P.C.

469 S. Kirkwood Rd. Kirkwood, MO 63122
(Woodbine Center)

2990 Highway K O'Fallon, MO 63368
(O'Fallon Crossing)

PATIENT INFORMATION

NAME _____ (LAST) _____ (FIRST) _____ (MI) MR. MRS. MS. DR. (TITLE - CIRCLE ONE)

ADDRESS _____ (NUMBER & STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

_____ – _____ – _____ (SOC. SEC. NUMBER) (_____) _____ – _____ (HOME PHONE) (_____) _____ – _____ (BUSINESS PHONE) _____ (EXT)

M F (SEX) _____ (DATE OF BIRTH) _____ (YOUR OCCUPATION) _____ (EMPLOYER) _____ (YRS WITH FIRM)

(_____) _____ – _____ (CELL NUMBER) _____ (E-MAIL ADDRESS)

RESPONSIBLE PARTY INFORMATION

_____ (RESPONSIBLE PARTY OCCUPATION) _____ (EMPLOYER) _____ (YRS WITH FIRM)

NAME _____ (LAST) _____ (FIRST) _____ (MI)

ADDRESS _____ (NUMBER & STREET) _____ (CITY) _____ (STATE) _____ (ZIP) (_____) (AC) _____ – _____ (HOME PHONE)

(_____) (AC) _____ – _____ (BUSINESS PHONE) _____ – _____ – _____ (SOC. SEC. NUMBER) M F (SEX) _____ (DATE OF BIRTH)

DENTAL INSURANCE INFORMATION

EMPLOYER _____ (COMPANY NAME) _____ (ADDRESS - NUMBER & STREET) _____ (CITY)

_____ (STATE) _____ (ZIP) (_____) (AC) _____ – _____ (EMPLOYERS PHONE) _____ (GROUP NUMBER) _____ (GROUP NAME)

_____ (INS. COMPANY NAME) _____ (ADDRESS NUMBER & STREET) _____ (CITY)

_____ (STATE) _____ (ZIP) (_____) (AC) _____ – _____ (INSURANCE PHONE NUMBER) _____ (EXT)

ADDITIONAL INFORMATION

_____ (SPOUSES OCCUPATION) _____ (EMPLOYER) _____ (YRS WITH FIRM)

SPOUSE _____ (FIRST NAME) _____ (MI) _____ (DATE OF BIRTH) _____ – _____ – _____ (SOC. SEC. NUMBER) (_____) _____ – _____ (AC) (BUSINESS PHONE) _____ (EXT)

IF YOU ARE COMPLETING THIS FORM FOR ANOTHER PERSON, WHAT IS YOUR RELATIONSHIP TO THAT PERSON? _____

PERSON TO CONTACT IN CASE OF EMERGENCY _____ (NAME) _____ – _____ (DAYTIME PHONE) _____ – _____ (EVENING PHONE)

I LEARNED OF YOUR OFFICE BY: ☐ REFERRED BY _____ (NAME) ☐ PHONE BOOK ☐ OFFICE SIGN ☐ OTHER _____ (PLEASE SPECIFY)

I UNDERSTAND THAT PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE. A MONTHLY CHARGE OF 1 1/2% PER MONTH (18% PER YEAR) WILL BE ADDED ON ALL ACCOUNTS NOT PAID WITHIN 30 DAYS.

IF I DEFAULT IN PAYMENT AND COLLECTION IS REQUIRED, I WILL BE RESPONSIBLE FOR ALL COLLECTION AND/OR ATTORNEY FEES AND COURT COSTS.

_____ (DATE)

_____ (SIGNATURE OF PATIENT OR GUARDIAN)

Medical History

PATIENT NAME _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ❍ Yes ❍ No ❍ N/A _____

Have you ever been hospitalized or had a major operation? ❍ Yes ❍ No Please List _____

Have you ever had a serious head or neck injury? ❍ Yes ❍ No ❍ N/A _____

Are you taking any medications, pills, or drugs? ❍ Yes ❍ No ***Please List*** _____

Have you ever taken medication or injections for osteoporosis? ❍ Yes ❍ No ***Please List*** _____

Do you take, or have you taken, Phen-Fen or Redux? ❍ Yes ❍ No ❍ N/A Do you use tobacco? ❍ Yes ❍ No ❍ N/A

Are you on a special diet? ❍ Yes ❍ No ❍ N/A Do you use controlled substances? ❍ Yes ❍ No ❍ N/A

Women: Are you ❑ Pregnant / Trying to get pregnant? ❑ Nursing? ❑ Taking oral contraceptives?

If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex ❑ Local Anesthetics ❑ Other _____

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

- ❑ AIDS/HIV Positive
- ❑ Alzheimer's Disease
- ❑ Anaphylaxis
- ❑ Anemia
- ❑ Angina
- ❑ Arthritis/Gout
- ❑ Artificial Heart Valve*
- ❑ Artificial Joint*
- ❑ Asthma
- ❑ Blood Disease
- ❑ Blood Transfusion
- ❑ Breathing Problem
- ❑ Bruise Easily
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Chest Pain
- ❑ Cold Sores/Fever Blisters
- ❑ Congenital Heart Disorder
- ❑ Convulsions
- ❑ Cortisone Medicine
- ❑ Diabetes
- ❑ Drug Addiction
- ❑ Easily Winded
- ❑ Emphysema
- ❑ Epilepsy or Seizures
- ❑ Excessive Bleeding
- ❑ Excessive Thirst
- ❑ Fainting Spells/Dizziness
- ❑ Frequent Cough
- ❑ Frequent Diarrhea
- ❑ Frequent Headaches
- ❑ Genital Herpes
- ❑ Glaucoma
- ❑ Hay Fever
- ❑ Heart Attack/Failure
- ❑ Heart Murmur*
- ❑ Heart Pace Maker*
- ❑ Heart Trouble/Disease
- ❑ Hemophilia
- ❑ Hepatitis A
- ❑ Hepatitis B or C
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ Hives or Rash
- ❑ Hypoglycemia
- ❑ Irregular Heartbeat
- ❑ Kidney Problems
- ❑ Leukemia
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Lung Disease
- ❑ Mitral Valve Prolapse*
- ❑ Osteoporosis
- ❑ Pain in Jaw Joints
- ❑ Parathyroid Disease
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Recent Weight Loss
- ❑ Renal Dialysis
- ❑ Rheumatic Fever*
- ❑ Rheumatism
- ❑ Scarlet Fever
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Trouble
- ❑ Snoring/Sleep Apnea
- ❑ Spina Bifida
- ❑ Stomach/Intestinal Disease
- ❑ Stroke
- ❑ Swelling of Limbs
- ❑ Thyroid Disease
- ❑ Tonsilitis
- ❑ Tuberculosis
- ❑ Tumors or Growths
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Yellow Jaundice

Have you ever had any serious illness not listed above? ❍ Yes ❍ No ❍ N/A _____

Comments: _____

_____

_____

*Condition may require medication N/A - Not answered by patient

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE

_____ _____

REVIEWED BY DOCTOR DATE

I understand that I am responsible for any missed appointment fees should I neglect to keep my scheduled appointment without at least 24 hours notice.

SIGNATURE _____

DATE _____

Dental History

Name:_____

Type of Dental Treatment Desired (Check one)

- ❑ Emergency (Relief of pain and treatment of chief complaint only)
- ❑ Complete (Initial examination and treatment as required)
- ❑ Consultation (Please specify)_____
- ❑ Other_____

Date of last dental treatment:_____

Dental services received:_____

Describe chief dental concern:_____

Please Check:	YES	NO
Do you feel discomfort in your teeth when chewing?	❑	❑
Do you have any places where food packs between teeth?	❑	❑
Do you feel discomfort in your jaw or ears when chewing?	❑	❑
Do you have pain, discomfort, sores, or lumps anywhere in your head or neck area?	❑	❑
Do you suffer frequent headaches?	❑	❑
Do you clench or grind your teeth?	❑	❑
Do your gums bleed when chewing or brushing?	❑	❑
Have you ever been treated for gum disease?	❑	❑
Do you have unpleasant breath or an unpleasant taste in your mouth?	❑	❑
Are you confident in your ability to properly clean your teeth?	❑	❑
Do you feel you chew efficiently?	❑	❑
Are you pleased with the appearance of your teeth?	❑	❑
Have you noticed any darkening of your teeth?	❑	❑
Have you lost any teeth?	❑	❑
If so, were they replaced?	❑	❑
Do you feel you will eventually lose all of your teeth even with proper care?	❑	❑
Do any members of your family, including your parents, wear dentures or partials?	❑	❑
Are you concerned about the finances required to return your mouth to excellent dental health?	❑	❑
Do you get frustrated because you always have something to be treated or repaired when you visit the dentist?	❑	❑

If, by magic, you could change anything about your teeth, what would you change? _____

_____