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

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 (____) AC ______ – ______ HOME PHONE (____) AC ______ – ______ 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 A 30% COLLECTION FEE AND/OR ATTORNEY FEES AND COURT COSTS.

____________ DATE ____________ SIGNATURE OF PATIENT OR GUARDIAN

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? ____

____

	YES	NO
Do you have any interest in cosmetic injectables?	❑	❑

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

Physician name and phone # ____

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 ❑ Sulfa ❑ 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
❑ High Cholesterol
❑ 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 ____________________