

Briggs Family & Cosmetic Dentistry

PATIENT REGISTRATION

Patient Information

Date			
Patient's NameLast	First	Preferred Name	
Address	First	Birth Date	
City	State Zip 0	Code Social Security #	
Home Phone #	Cell #	Work #	
E-Mail Address			
Gender: □ Male □ Female	Marital Status:	□ Married □ Single □ Divorced □ Separated □ Widowed	
Who may we thank for referring you t	o our office?		
	D	La Danta Information co	
21	•	le Party Information (if someone other than patient)	
NameLast		Middle Birth-date	
Address		Social Security #	
		Work #	
Relationship to Patient		o change or cancel any appointments – or a \$50.00 charge will be assessed to your a	ecount.
we ask that you please notify us at least 40 h	ours in advance is needing to	o change of cancer any appearances.	
	Insura	ance Information	
Name of Primary Insured		Relationship to Patient Self Spouse Child	Other
Insured SS# or Alternate ID#		Insured Birth Date	Andrews of the State of the Sta
Name of Insurance Co.		Employer	
Address		Address	
City, State, Zip		City, State, Zip	
Phone #		Phone #	
Name of Secondary Insured		Relationship to Patient □Self □Spouse □Child □	Other
Insured Social Security			
Name of Insurance Co.		7.77	
Address		0: 0. 7'	
City, State, Zip			
Phone #		Phone #	

Date 2/9/2017

Briggs Family And Cosmetic Dentistry MEDICAL HISTORY Birth Date:

Date Created:

Patient Name:

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have, or medication(s) 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 If yes Have you recently been hospitalized or seen at Yes No If ves urgent care? Have you ever had a serious head or neck injury? Yes No If yes Are you taking any medications, pills, and/or Yes No If yes supplements? If so, please list: Have you ever taken Fosamax, Boniva, Actonel, or Yes No If yes any other medications containing bisphosphonates? Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes Do you routinely drink soda, energy drinks, or Yes No orange juice? Do you use or have you ever used tobacco? Yes No Do you use or have you used controlled substances? Yes No Have you been told to premedicate prior to dental Yes No treatment? If so, list the physician and why Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Sulfa Drugs Local Anesthetics other? Yes No " WOMEN ONLY Pregnant/ Trying to get pregnant? Nursing? Taking oral contraceptives? Hormone Replacement Therapy? Perimenopausal/ Menopausal? Do you have, or have you had, any of the following? AIDS/HIV Positive Yes No Allergies Yes No Alzheimer's Disease Yes No Anaphylaxis Yes No Anemia Yes No Angina Yes No Arthritis Yes No Artificial Heart Valve Yes 110 Artificial Joint Yes No Asthma Yes No **Blood Disease** Yes No **Breathing Problems** Yes 110 Cancer Yes No Chemotherapy Yes No Chest Pain Yes No Cold Sores Yes 110 Congenital Heart Disorder Yes No Convulsions Yes No Diabetes Yes 110 Drug Addiction Yes 110 Eating Disorder Yes No Easily Winded Yes No Emphysema Yes 110 Epilepsy or Seizures Yes No Excessive Bleeding Yes No Excessive Thirst · Yes · No Yes Fainting/ Dizziness No Frequent Cough Yes 110 Frequent Headaches Yes Glaucoma Yes No Hard of Hearing/Hearing Yes 110 Hay Fever Yes 110 Heart Attack/Failure Yes No Aids Heart Murmur Yes No Heart Trouble/Disease Yes 110 Hemophilia Yes No Yes No Heart Pacemaker Yes No Hepatitis A Herpes (cold sores) Yes High Blood Pressure Hepatitis B or C O No (Yes No Yes High Cholesterol Yes No Hypoglycemia Yes 110 Low Blood Pressure Yes No Hives or Rash YAS 110 Lung Disease Yes No Multiple Sclerosis Yes No Osteopenia/Osteoporosis Mitral Valve Prolapse Yes No Pain in Jaw Joints Yes (No Yes 110 Psychiatric Care Yes 110 Radiation Treatment Yes Parathyroid Disease Yes No Recent Weight Loss No Yes No Scarlett Fever Yes 110 Shingles/ Chicken Pox Yes No Rheumatic Fever Yes No Sinus Trouble Yes No Sleep Apnea Yes Ho Stomach/Intestinal Disease Yes No Sjogren's Syndrome Yes 110 Stroke Yes No Thyroid Disease Yes 110 **Tonsilitis** Yes No Swelling of Limbs Yes No Tuberculosis Yes No Ulcers Yes 110 Venereal Disease Yes · No Tumors or Growths Yes 110 Have you had any serious illness not listed? Yes No If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information may 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:

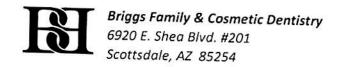


Briggs Family & Cosmetic Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been informed of the September 2013 Revision

I have Office's Notice of Privacy Practices.	e received/read a copy of this
I give the following permission to Briggs Fa	amily Dentistry:
I give this office permission to speak with: regarding my account billing, dental health an (Excludes medical providers)	nd/or treatment needs.
I give this office permission to correspond via	text and email:
Cell Number	Email Address
Signature of Patient	
Printed Name of Patient	Date
- Office Us	se Only -
We attempted to obtain written acknowledgement of reacknowledgement could not be obtain because:	ceipt of our Notice Privacy Practice, but
Individual to sign	
Communication barriers prohibit	ted obtaining the acknowledgement
An emergency situation prevented	ed us from obtaining acknowledgement



Sleep Disorders Breathing Screening

Patient Name: Date:				
DOB: Gender: M F	_			
Have you been told you snore?	Yes	No		
Do you ever choke or gasp while you sleep?	Yes	No		
Do you feel tired, fatigued or sleepy during the day?	Yes	No		
Do you experience chronic nasal congestion?	Yes	No		
Do you have high blood pressure?	Yes	No		
Do you have acid reflux/GERD?	Yes	No		
	0			
Have you had an overnight sleep study?	Yes	No		
If yes, approximate date Do you have a CPAP?	Voc			
If yes, do you use your CPAP nightly? Yes	Yes No	No		
	NO			
Large Tonsils Scalloped/Large Tongue Narrow Palate Additional Notes: Patient appears to have minimal risk of Sleep Disorders	S 870	According to the second		
Recommended Nex	t Steps			
Diagnostic Sleep Test Oral Appliance Consulta Educational Brochures given to patient Informational Resources Handout given to patient Gave patient information on Snore Lab app for phone		rral to Specialist		
Notes:				