WELCOME

Thank you for selecting our dental health care team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – *we will be happy to help!*

PATIENT INFORMATION (Confidential)

Today's Date _____

Name: _____ Birthdate: _____

Address: _____ Home Phone: _____

Address Line 2: _____ Work Phone: _____

City: _____ State: ____ Zip: _____ Cell Phone: _____

Social Security #: _____ Email Address: _____

Person to Contact in Case of Emergency: _____ Phone: _____

What Dentist Referred You? _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account: _____

Relationship to Patient: _____ Employer: _____

Address: _____ Employer Address: _____

Address Line 2: _____ Address Line 2: _____

City: _____ State: ___ Zip: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Work Phone: _____

DENTAL INSURANCE INFORMATION

Name Of Policy Holder: _____ Birthdate: _____

Relationship to Patient: _____ Social Security # or ID #: _____

Employer: _____ Insurance Company: _____

Work Phone: _____ Address: _____

Insurance Group #: _____ City: _____ State: _____ Zip: _____

ADDITIONAL DENTAL INFORMATION

Do You Have Secondary Dental Insurance? _____ No _____ Yes (If Yes, Please Fill Out Below)

Name Of Insured: _____ Birthdate: _____

Relationship to Patient: _____ Social Security # or ID #: _____

Employer: _____ Insurance Company: _____

Work Phone: _____ Address: _____

Insurance Group #: _____ City: _____ State: _____ Zip: _____

▶ PLEASE TURN SHEET OVER AND COMPLETE THE BACK.

BRIAN HALL DDS, PA
ENDODONTIST

604 Solarex Court • Suite 202 • Frederick, Maryland 21703 Ph: 301.696.2000 fx: 301.696.0099 e: info@briandhall.com w: briandhall.com

ADDITIONAL PATIENT INFORMATION (Please respond to each question)

(Please Circle Your Answer Below)

Yes | No 1. Are you under medical treatment now?

Yes | No 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain.

Yes | No 3. Are you taking any medication(s) including non prescription medicine? If yes, what medication(s) are you taking?

Yes | No 4. Do you use tobacco?

Yes | No 5. Do you use controlled substances?

Yes | No 6. Are you wearing contact lenses?

7. Women Only

Yes | No a. Are you pregnant or think you may be pregnant?

Yes | No b. Are you nursing?

Yes | No c. Are you taking oral contraceptives?

8. Are you allergic to or had reactions to the following? (Check All That Apply)

____Local Anesthetics (e.g. Novocaine)
____Penicillin
____Other Antibiotics
____Sulfa Drugs
____Barbiturates
____Sedatives
____Iodine
____Aspirin
____Any Metals (e.g. nickel,mercury, etc.)
____Latex Rubber
____Other: (Please List Below)

_____

9. Do you have any of the following? (Check All that Apply)

____High Blood Pressure
____Low Blood Pressure
____Chest Pains
____Heart Murmur
____Heart Trouble
____Heart Disease
____Mitral Valve Prolapse
____Cardiac Pacemaker
____Angina
____Cancer
____Radiation Therapy
____Leukemia
____Stroke

____Diabetes
____Anemia
____Fainting / Seizures
____Epilepsy / Convulsions
____Sexually Transmitted Disease
____Hepatitis & Type:
____Arthritis
____Joint Replacement or Implant
____Swollen Ankles
____Liver Disease
____Kidney Disease
____Thyroid Problem
____Stomach Troubles / Ulcers

____Respiratory Problems
____Easily Winded
____Asthma
____emphysema
____Tuberculosis
____Hay Fever / Allergies
____Recent Weight Loss
____Frequently Tired
____Other: (Please List Below)
_____
_____
_____
_____

Physician's Name _____ Phone: _____

AUTHORIZATION AND RELEASE:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child/guard during the period of such Dental care to third party payers and /or health practitioners. I understand this office is not an insurance subscriber and will file my claims to my insurance company for me, provided I have all given all of the information requested by the insurance company for payment.

_____ Signature of Patient (or parent/guardian if minor)