Sebastian Bouroncle DDS

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Welcome! Thank you for selecting our dental office. To help us meet all your health care needs, please complete this form as accurately as possible.

1) PATIENT INFORMATION

Patient full name: _____ Social Security # _____

Birth Date: _____ Age: _____ Male _____ Female _____

Marital Status: Married _____ Single _____ Other _____ How did you hear about our office? _____

Address: _____ City: _____ State _____Zip C _____

Employer : _____ Occupation: _____

Previous Dentist : _____ Previous Dentist Phone: _____

Current Physician: _____ Physician Phone #: _____

Full Time Student: _____

2) TELEPHONE & EMAIL

Home Phone: _____ Work Phone: _____ Cell # _____

Email: _____

In case of an emergency, who should we contact?

Name: _____ Relationship: _____

Home Phone: _____ Cell #: _____

3) RESPONSIBLE PARTY

Who is responsible for this patient? _____ Relationship: _____

Social Security # _____ Birth Date: _____

Address: _____ City: _____ State _____ Zip C _____

Employer: _____ Home Ph: _____ Work Ph: _____

4) INSURANCE INFORMATION

PRIMARY INSURANCE

Name of Ins. Holder: _____ Relationship:_____

Insured's SSN : _____ Birth Date: _____

Ins. Company name: _____ Employer: _____

Group # _____ ID # _____ Ins. Phone Number _____

SECONDARY INSURANCE

Name of Ins. Holder: _____ Relationship:_____

Insured's SSN : _____ Birth Date: _____

Ins. Company name: _____ Employer: _____

Group # _____ ID # _____ Ins. Phone Number _____

5) **MEDICAL HISTORY**

Do you consider yourself in good medical health? ☐ Yes ☐ No
Do you smoke or use tobacco in any forms ☐ Yes ☐ No
Do you have any metal rods, pins or Orthopedic Implants? ☐ Yes ☐ No
Do you require to PREMEDICATE for any MEDICAL CONDITIONS? ☐ Yes ☐ No
Are you taking any prescription/over the counter or herbal supplemental drugs? ☐ Yes ☐ No
Please list all medications currently taken: _____

_____.

Have you ever taken Fosamax, Actonel, Boniva, Didronel, Skelid or any medication for Osteoporosis? ☐ Yes ☑ No
Do you take any Blood thinners (Aspirin, Plavix, Coumadin…)? ☐ Yes ☑ No
Have you ever taken Phen- Phen? ☐ Yes ☑ No

For Women:

Are you Pregnant? ☐ Yes ☐ No / Nursing? ☐ Yes ☐ No ****** If Pregnant, week #** _____
Do you take Birth Control Rx.? ☐ Yes ☐ No

Have you ever had any of the following medical problems?

Abnormal bleeding	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Alcohol/drug abuse	☐ Yes ☐ No	HIV/AIDS	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Liver Problems	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No
Artificial Bones/Joints/Valves	☐ Yes ☐ No	Lupus	☐ Yes ☐ No
Blood Transfussion	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Cancer/Chemo	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Colitis	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Congenital Heart Deffect	☐ Yes ☐ No	Psychiatric Problems	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No
Difficulty breathing	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Epilepsy/Seizures	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Heart Attack	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Heart Surgery	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Hemophilia	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No	Other : _____	
Herpes/Fever Blisters	☐ Yes ☐ No	_____	

Are you allergic to the following:

Aspirin	☐ Yes ☐ No	Erythromycin	☐ Yes ☐ No	Tetracycline	☐ Yes ☐ No
Codeine	☐ Yes ☐ No	Latex	☐ Yes ☐ No	Penicillin	☐ Yes ☐ No

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

6) **DENTAL HISTORY**

What is the reason for your visit today? _____ Are you currently in pain? ☐ Yes ☐ No
Have you ever had difficulties associated with any previous Dental work? ☐ Yes ☐ No
Have you ever had Gum treatment? ☐ Yes ☐ No
Have you ever had pain in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No
Do your gums bleed? ☐ Yes ☐ No
Are your teeth sensitive to hot, cold or both? ☐ Yes ☐ No
When was the last time you had a cleaning? _____ How many times a week do you floss? _____

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 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.

_____ _____
Patient/ Guardian Signature Date