PATIENT INFORMATION

Last Name ________________First Name _______________Middle Initial ___

Address__________________________City_____________State___Zip______

Home Phone _________Work Phone _________ Cell # _________

E-mail address ___________________ May we confirm appts. via e-mail? _____

Marital Status M__W__S__D___ DOB ___________

Employer_________________ Address __________________________________

Name & Phone # of your pharmacy _____________________________________

What is the best phone # to reach you between the hours of 9:00 a.m.-5:00 p.m.? _______

Person to contact in case of emergency (*not living with you)*
_______________________Phone ____________ Relationship ___________

Did you visit our website www.tricitiesendo.com? ___Yes ___No

DENTAL HISTORY

Name of your general dentist ____

Did you bring x-rays? ____ Have you had a previous root canal treatment? ________

Have you ever had treatment for periodontal disease? ____ (ex. pyorrhea, gum disease)

Have you ever had a serious problem with dental treatment? _____ If so, please explain

____

Are you missing any teeth? ____ Do you have implants? ___

Are you wearing removable dental appliances? ____

DENTAL INSURANCE INFORMATION

Primary Insurance:
Subscriber's Name____________________ Relationship______________Date of Birth__________

Subscriber's Address______________________City_____________State_______ Zip_________

Subscriber's Home Phone#____________________Work Phone #__________________________

Subscriber's Employer_____________________________

Subscriber's Employer Address____

Name of insurance company______________________Address___________________________

Group#_____________ Insurance company Phone #_________________________

Permission to Release Dental/Financial Info

I, _____________________, do hereby give permission for Dr. Maria Bryan & her office staff to discuss my dental and or financial information with:

1.____________________________relationship__________________

2.____________________________relationship__________________

3.____________________________ relationship__________________

This authorization remains in effect until revoked by patient.

FINANCIAL INFORMATION

Payment is due at time of service.
As a courtesy to our patients we will file your insurance, after treatment is completed for reimbursement to you.
Please give receptionist a copy of your **dental** insurance card.
Service charges of $15.00 will be added to returned checks.
Your signature gives the doctor & staff permission to treat you, to release information to the insurance company, your dentist, and to obtain a credit history.
You also agree to the financial terms above.

Signature___________________________________ Date______________________

PATIENT Health History

Date____

(First Name) (Last Name)
(Street)
Kingsport, TN

Account
Member 01
Work Phone ( ) -
Home Phone ( ) -

Sex
DOB / /
Nickname
Chart #

First Visit
/ /
Last Visit
/ /

Employer None
Referred By None
General DDS None
Provider Maria Bryan, D.D.S. 001

- ☐ Mitral Valve Prolaps
- ☐ Heart Condition/Surg
- ☐ High Blood Pressure
- ☐ Respiratory/Asthma
- ☐ Rheumatic Fever
- ☐ Hypertension/Circula
- ☐ Immunocompromised
- ☐ Anemia/Bleeding
- ☐ Diabetes
- ☐ Herpes/Fever blister
- ☐ Thyroid/Hormonal
- ☐ Smoker/ ? PPD
- ☐ Retina surgery (8 wk
- ☐ TMJ Dysfunction
- ☐ Laughing gas
- ☐ HARD TO NUMB
- ☐ EASY TO GAG
- ☐
- ☐
- ☐
- ☐

- ☐ Ulcers/Digestive
- ☐ Migraine/Headaches
- ☐ Epilepsy/Fainting
- ☐ Glaucoma/Visual
- ☐ Psychiatric problems
- ☐ Cancer/ chemo
- ☐ Alcoholism/Addiction
- ☐ Infectious Diseases
- ☐ Venereal Disease
- ☐ Tuberculosis
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Hepatitis A B C
- ☐ Pacemaker
- ☐ Artificial joints
- ☐ Sinus Problems
- ☐ HIV/ AIDS
- ☐ Blood transfusion
- ☐ WOMEN: pregnant/nurs
- ☐
- ☐

Allergies

- ☐ Penicillin
- ☐ Antibiotics
- ☐ Aspirin
- ☐ Tylenol
- ☐ Codeine
- ☐ Narcotics
- ☐ Local Anesth
- ☐ Latex
- ☐ Clorox/Chemicals
- ☐ Iodine
- ☐ Sulfa
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐

Medications

- ☐ No Medications
- ☐ Antibiotic
- ☐ Pain Medicine
- ☐ Heart Medicine
- ☐ Aspirin
- ☐ Cortisone/Steroid
- ☐ Blood Thinner
- ☐ Blood Pressure
- ☐ Oral Contraceptives
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐

Notes
____
____
____
____

The information above is correct.

____________________ ____________
Name Date