



**Cosmetic and Family Dentistry**  
**Dr. G. Todd Brady**

Today's Date: \_\_\_\_\_

**Patient Information**

Patient Name: \_\_\_\_\_ I prefer to be called: \_\_\_\_\_  
 Last First Middle

Male  Female  Married  Single  Divorced  Child Age: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_

E-mail: \_\_\_\_\_ Fax: \_\_\_\_\_ Mobil/Cell: \_\_\_\_\_

Address: \_\_\_\_\_  
 Street City State Zip

**Health Information**

Previous Dentist: \_\_\_\_\_ Date of Last Dental Visit: \_\_\_\_\_

Reason for this visit: \_\_\_\_\_

Have you ever had any of the following? Please check those that apply:

- AIDS/HIV+  Excessive Bleeding  Lupus  Stomach Problems
- Allergies \_\_\_\_\_  Fainting  Mental/Nervous Disorders  Stroke
- Anemia  Fever Blisters  Mitral Valve Prolapse  Tuberculosis
- Arthritis  Glaucoma  Pacemaker  Tumors
- Artificial Joints  Hay Fever  **Pregnancy** : Due date: \_\_\_\_\_  Ulcers
- Artificial Valves  Head Injuries  Radiation Treatment  Venereal Disease
- Asthma  Heart Disease  Respiratory Problems
- Blood Disease  Heart Murmur  Radiation Treatment
- Cancer  Hepatitis  Rheumatic Fever
- Diabetes  High Blood Pressure  Rheumatism
- Dizziness  Jaundice  Scarlet Fever
- Drug Abuse  Kidney Disease  Sickle Cell Anemia
- Epilepsy  Liver Disease  Sinus Problems

Are you allergic to any of the following?

- Aspirin  Latex
- Barbiturates  Penicillin
- Codeine  Sedatives
- Dental Anesthetics  Sulfa Drugs
- Erythromycin  Tetracycline
- Jewelry/Metals  Other

Please list additional drugs/materials that cause allergic reactions:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Are you taking any of the following?

- Acetaminophen  Blood Thinners  Insulin/Diabetes Drugs  Thyroid Medicine
- Antibiotics  Blood Pressure Medication  Nitroglycerin  Tranquilizers
- Antihistamines  Cold Remedies  Recreational Drugs  Have you ever taken Phen-Fen? Also known as Redux or Pondimin?
- Aspirin  Digitalis/Heart Medication  Steroids/Cortisone  Yes  No

Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above?

Yes  No If yes, please list each one: \_\_\_\_\_

Do you or any of your family have sleep apnea or snoring problems?  Yes  No

Have you ever had any complications following dental treatment?  Yes  No

If yes, please explain: \_\_\_\_\_

Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No

If yes, please explain: \_\_\_\_\_

Are you now under the care of a physician?  Yes  No

If yes, please explain: \_\_\_\_\_

Name of Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

## Cosmetic Information

Is there anything about your smile that you do not like? \_\_\_\_\_

Are you interested in knowing the options available for a more beautiful smile? \_\_\_\_\_

Do you like the appearance of your teeth? \_\_\_\_\_

Are all of your teeth in alignment (straight)? \_\_\_\_\_

Do you have any missing teeth? \_\_\_\_\_ Are any chipped? \_\_\_\_\_

Is your bite comfortable when chewing or biting? \_\_\_\_\_

Do you have frequent headaches? \_\_\_\_\_

Do you have any old fillings or dental treatment that you are unhappy with? \_\_\_\_\_

What would you like to change the most about the appearance of your teeth? \_\_\_\_\_

Is there anything else you would like us to know? \_\_\_\_\_

## Spouse and Responsible Party Information

Spouse Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Driver's License#: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Person responsible for account:  Self  Spouse  Other \_\_\_\_\_

## Insurance Information

### Primary Dental Insurance

Insurance Company Name: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_  
Street/PO Box City State Zip

Phone: \_\_\_\_\_ Group #(Plan, Local or Policy#): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Social Security: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Address: \_\_\_\_\_

### Secondary Dental Insurance

Insurance Company Name: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_  
Street/PO Box City State Zip

Phone: \_\_\_\_\_ Group #(Plan, Local or Policy#): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Social Security: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Address: \_\_\_\_\_

## Referral Information

Whom may we thank for referring you to our practice?  Another patient, friend  Another Dentist  Dental Office

Living Magazine  School  Work  Website  Other \_\_\_\_\_

Name of person or office referring you to our practice: \_\_\_\_\_

## Employment Information

The following is for:  the patient  the person responsible for payment

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

## Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon payment from the patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed.

I understand and acknowledge that photographs and images of me may be shown to other doctors for treatment and educational purposes.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I authorize my insurance company to pay the office of G Todd Brady, DMD all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance claims submission. I authorize the release of all information necessary to secure payments of insurance benefits. I understand that I am financially responsible for all fees regardless of whether or not they are covered by insurance.

I have read, understand and accept the terms of the above outlined guidelines for insurance handling and financial commitments that I may incur.

After 60 days from the treatment date, I authorize G. Todd Brady, DMD to bill my credit card to pay any remaining balances left on my account.

\_\_\_\_\_  
Credit Card Number & Type Expiration Date

\_\_\_\_\_  
Signature Date

I have read the above conditions of treatment and payment and agree to their content.

\_\_\_\_\_  
Signature of patient, parent or guardian Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_