BUTTE FAMILY DENTAL PPLC

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PATIENT PROFILE

PLEASE PRINT

Name ____________________

Address ____________________

City____________ Zip Code__________

Telephone__________ Cell Phone__________

Birth Date__________ Sex M F

☐ Single ☐ Married ☐ Widowed ☐ Divorced

Email____________________

Referred By____________________

Occupation __________ Work Phone__________

Employed by____________________

Soc. Sec. #__________ Policy #__________

Name of Spouse (Parent if minor)__________

Date of Birth__________ Soc. Sec. #__________

Occupation__________ Work Phone__________

Employed by____________________

Are you in good health? ☐ Yes ☐ No

Has there been any change in your health in the past year?
☐ Yes ☐ No

Are you being treated for any condition by a physician now?
☐ Yes ☐ No

If yes explain: ____________________

Your physician is: ____________________

Women, are you pregnant? ☐ Yes ☐ No

Taking Birthcontrol Medication ? ☐ Yes ☐ No

Do you take any prescriptions or medicines? ☐ Yes ☐ No

If so, what?____________________

Preferred Pharmacy ____________________

Are there any medicines that you are allergic to or cannot take?
☐ Yes ☐ No

Which Ones: ____________________
____

Are you latex sensitive ? ☐ Yes ☐ No

Have you ever had or taken the following? Please check all that apply

- ☐ Heart Disease
  - ☐ Heart murmur
  - ☐ Heart attack
  - ☐ Rheumatic fever
- ☐ Artifical limbs, joints, ETC.
- ☐ Headaches
- ☐ Face or jaw injury
- ☐ Hearing difficulties
- ☐ Stroke
- ☐ Breathing / Lung Problems
- ☐ Surgery within last year

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- ☐ Anemia
- ☐ Ulcers
- ☐ Allergies
- ☐ Asthma
- ☐ Hay Fever
- ☐ Sinus trouble
- ☐ Arthritis
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Cancer or Blood Disorder

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- ☐ AIDS/HIV
- ☐ Cocaine or street drugs
- ☐ Hepatitis or liver trouble
- ☐ Glaucoma or Eye Disease
- ☐ Venereal disease
- ☐ Tuberculosis
- ☐ Psychiatric Treatment
- ☐ Stomach Problems
- ☐ Other Pertinent Information

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Please Check Any That You Experience:

- ☐ Clicking jaw joint
- ☐ Habits such as nail biting, chewing on pencils or a pipe, etc.__________
- ☐ Bad odors or tastes from your mouth
- ☐ Grinding Teeth
- ☐ Sleep Apnea
- ☐ Snoring

- ☐ Clenching Teeth
- ☐ Smoking– How Much __________
- ☐ Chewing Tobacco How Much __________
- ☐ Other Dental Problems __________

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Have you ever had any of the following?

- ☐ Orthodontic Treatment (Braces)
- ☐ Periodontal Treatment
- ☐ Unpleasant Dental Experiences

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Health Hx Update

OVER →

Acknowledgement of receipt of notice of privacy practices.
Consent for use and disclosure of health information.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations until revoked. I authorize payment directly to and authorize endorsement of all insurance checks to Dr. William Brennick, D.D.S., P.C. and/or Dr. Tara Eller, D.D.S., and/or Butte Family Dental PLLC. I also assume responsibility for unpaid balance after insurance has been paid.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to our office. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we receive your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent. I understand that I may refuse to sign this form.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations for 30 months. I have received a copy of this office's Notice of Privacy Practices.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature: ____________________________________DOB: ___________________Date:_________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:____

Relationship to Patient:____

You are entitled to a copy of this Consent after you sign it.

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