BRIAN KIRKWOOD, D.D.S. Case #_____

BRANDYWINE DENTAL GROUP, P.C.

PATIENT INFORMATION
(Please print)

Name _____
Address _____
City & Zip _____
Home Phone _____
Work Phone _____
Cell Phone _____
Best Phone # to reach you _____
Email Address _____
Emergency Phone _____
Age _____ Birthdate _____
Employer _____
Physician _____

DENTAL BENEFITS

Name _____
Employer _____
Address _____
City & Zip _____
Work Phone _____
Insurance Co. _____
Secondary Ins. Co. _____
Group/Plan # _____
Soc. Sec. # _____
Birthdate _____

Sex _____ Marital Status ☐ S ☐ M ☐ D ☐ W
Occupation _____
Patient Soc. Sec. # _____

Previous Dentist _____
Whom may we thank for referring you to our office? _____

MEDICAL HISTORY OF PATIENT *(Please check those conditions that now or have ever pertained to you)*

Yes	No		Yes	No	
☐	☐	Heart murmur or congenital heart defect	☐	☐	Joint replacement (hip, knees . . .)
☐	☐	Heart surgery or heart disease	☐	☐	Convulsions or epilepsy
☐	☐	Rheumatic fever	☐	☐	Dizziness or fainting spells
☐	☐	Heart pacemaker	☐	☐	Stroke
☐	☐	Abnormal blood pressure high / low	☐	☐	Lung problems
☐	☐	Bleeding problems	☐	☐	Tuberculosis (T.B.)
☐	☐	Diabetes	☐	☐	Thyroid disease
☐	☐	Kidney disease	☐	☐	Glaucoma
☐	☐	Jaundice or liver disease	☐	☐	Ulcers/stomach disorders
☐	☐	Cancer or tumors	☐	☐	Arthritis
☐	☐	Hepatitis	☐	☐	Blood diseases, i.e. Anemia
☐	☐	Venereal disease	☐	☐	Sinus trouble
☐	☐	AIDS or HIV positive	☐	☐	Severe headaches
☐	☐	Allergic or sensitive to medication, drugs	☐	☐	Females only: Are you pregnant?
		(List below) _____	☐	☐	Have you ever taken a bisphosphonate medication, such as Osteoporosis medication?
			☐	☐	Are you presently taking medication?
					(If yes, please list and give reason for taking)
☐	☐	Are you currently under the care of a physician?			
		(List reasons) _____			
☐	☐	Do you smoke?			Other medical problems not listed above
☐	☐	Do you chew tobacco or snuff?			

DENTAL HISTORY OF PATIENT *Do you have or have you ever had any of the following?*

Yes	No		Yes	No	
☐	☐	Bleeding or sore gums	☐	☐	Loose/shifting teeth
☐	☐	Sensitivity to hot/cold/sweets	☐	☐	Food trapped between teeth
☐	☐	Complications from extractions	☐	☐	Periodontal (gum) treatment
☐	☐	Orthodontic treatment	☐	☐	Clinching or grinding of teeth
☐	☐	Do you floss or brush daily?	☐	☐	Pain/clicking/popping of jaw
☐	☐	Are you having pain or discomfort at this time?	☐	☐	Ever had complications following dental treatment?
☐	☐	Are you unhappy with the appearance of your teeth?	☐	☐	Nervous or apprehensive about your dental treatment?
			☐	☐	Ever had an unusual reaction to dental anesthetic?

Date of last dental exam _____

OFFICE POLICY

1. Before treatment can be rendered, adequate radiographs of the teeth and mouth must be taken.
2. Unless otherwise arranged, payment for professional service is required on the day the treatment is rendered. With prior approval, on certain extended procedures and treatment, payment plans can be arranged.
3. Please give at least 24 business hours notice if you cannot keep your appointment. Failure to do so can result in a failed appointment fee.

PERMISSION FOR TREATMENT AND PROMISE OF PAYMENT

This is to certify that I, the undersigned, consent to the performance of any and all procedures and all drugs that are agreed to be necessary or advisable. All of my treatment options will be explained to me either verbally or in writing. I understand that the use of anesthetic could cause parathesia. I also agree to accept full responsibility for the payment of all fees associated with those costs incurred in the collection of those fees, including attorney fees and 18% interest on overdue accounts.

Signed: _____ Date _____
(Patient, or Parent if Minor under age 18)

Relationship to Patient: _____