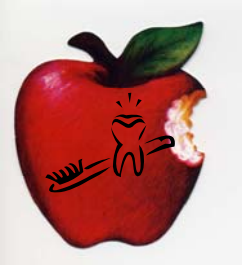

Welcome to Dr. Bruce R. Baral Dental Office

This information is necessary for our files and it is considered confidential to our office.

Date: _____

Patient Information

Patient's Last Name _____ First Name _____ Middle Initial _____ Title _____

Current Home Address _____ City _____ State _____ Zip Code _____

(_____) _____ Home Phone Number (_____) _____ Work Phone Number Ext. (_____) _____ Cell Phone Number

Date of Birth: *Month/Day/Year* _____ Social Security Number _____ - _____ - _____

If a Student, Name of School/College _____ Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Relationship _____ (_____) _____ Phone Number

Primary Dental Insurance Information

Insured Member's Full Name _____ Date of Birth: *Month/Day/Year* _____ Social Security Number _____ - _____ - _____

Insurance Company Name _____ Group Number _____ Relationship to Patient _____

Employer Name _____ Full Address of Employer _____

Does patient have additional Dental Insurance? ☐ Yes ☐ No

Insured Member's Full Name _____ Date of Birth: *Month/Day/Year* _____ Social Security Number _____ - _____ - _____

Insurance Company Name _____ Group Number _____ Relationship to Patient _____

Employer Name _____ Full Address of Employer _____

Responsible Party Information

This information is required for any charges that are not covered by insurance and that are my responsibility as a patient.

Name of Person Responsible for this Account _____ Relationship to Patient _____ Social Security Number _____ - _____ - _____

Current Home Address _____ City _____ State _____ Zip Code _____

(_____) _____ Home Phone Number (_____) _____ Work Phone Number Ext. (_____) _____ Cell Phone Number

Is this person currently a Patient in our office? ☐ Yes ☐ No

For All Patients

I herby authorize the doctor to perform any and all forms of treatment, medications, and therapy, that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that prior to treatment; the doctor and/or his staff will give full explanation of the procedure(s) involved. I agree to pay for all services rendered by this office.

Signature of Patient or Responsible Party _____ Relationship _____ Date _____

Please Complete Reverse Side

Medical Health History

Do you have a Medical Doctor? ☐ Yes ☐ No

Medical Doctor's Name | City | Date of Last Physical

*Please mark either **Yes** or **No** to indicate if you currently have or have ever had any of the following:*

Yes	No		Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Heart Problems	☐	☐	Asthma	☐	☐	Kidney Problems	☐	☐	Hearing Impaired	☐	☐	Chronic Sinus
☐	☐	Heart Murmur	☐	☐	Diabetes	☐	☐	Excessive Bleeding	☐	☐	Nervous Problems	☐	☐	Chronic Ear Problems
☐	☐	Mitral Valve Prolapse	☐	☐	Tonsils Removed	☐	☐	Circulatory Problems	☐	☐	Tuberculosis	☐	☐	Phen-Fen/Redux
☐	☐	Pacemaker	☐	☐	Rheumatic Fever	☐	☐	Malignancies	☐	☐	Emphysema	☐	☐	Venereal Disease/Herpes
☐	☐	High Blood Pressure	☐	☐	Epilepsy	☐	☐	Radiation Treatment(s)	☐	☐	Arthritis	☐	☐	H.T.L.V.
☐	☐	Low Blood Pressure	☐	☐	Scarlet Fever	☐	☐	Chemotherapy	☐	☐	Thyroid Problems	☐	☐	H.I.V.
☐	☐	Prosthetic Joint(s)	☐	☐	Hepatitis _____	☐	☐	Cancer _____	☐	☐	Anemia	☐	☐	A.I.D.S.

If **yes**, year joint replaced: _____

Other illnesses or conditions - Please list all other current or past significant illnesses or conditions (*include date of onset)*:

_____ _____ _____

_____ _____ _____

Medications - Please list medications you are currently taking*:*

_____ _____ _____

_____ _____ _____

Allergies - Causing swelling, rash, hives, itching, or difficulty breathing:
*Please mark either **Yes** or **No** to indicate if you currently have or have ever had any allergic reaction to the following:*

Yes	No		Yes	No		Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Local Anesthetic	☐	☐	Latex	☐	☐	Penicillin	☐	☐	Codeine	☐	☐	Aspirin	☐	☐	Sulfa	☐	☐	Iodine

Other Allergies: _____

(Women Only) Are you pregnant? ☐ Yes ☐ No If **Yes**, How many months? _____

Dental Health History

Name of Previous Dentist | City | Date of Last Visit | Date of last dental X-Rays

*Please mark either **Yes** or **No** to indicate if you currently have any of the following:*

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Sensitive teeth	☐	☐	Sores or growths in your mouth	☐	☐	Clicking or sore jaw	☐	☐	Are you happy with the color of your teeth?
☐	☐	Bleeding or sore gums	☐	☐	Loose teeth or broken fillings	☐	☐	Braces	☐	☐	Are you happy with your smile?

Other Dental Problems: _____

If Patient is a child, is this their first visit to a Dentist? ☐ Yes ☐ No

Are you aware of any dental problems that your child may have: _____

For All Patients

I herby state that I have answered all of the above questions truthfully and have given all information concerning my heath and medical history.

Signature of Patient or Responsible Party | Relationship | Date

For Office Use Only: