Brian L. James, D.D.S.
613 16th Avenue S.E. • Dyersville, IA 52040
(563) 875-9180

PATIENT INFORMATION (CONFIDENTIAL)

Patient # ____________________________

Date ________________________________

Name ____ Birth Date ______________ Social Security # ______________________

Home Address ____ Home Phone _____________________

City ____ State ___________________ Zip ____________ Cell Phone ______________________

Email Address ____

Sex: Male ______ Female ______ ______ Minor ______ Single ______ Married ______ Divorced ______Widowed

Patient's or Parent's Employer ____ Work Phone _____________________

Business Address _____________________________________ City ___________________________________ State ________ Zip _________

Spouse or Parent's Name ____________________________________ Employer ___________________ Work Phone _____________________

Who is financially responsible for this bill? ____

Whom may we thank for referring you? ____

Person to contact in case of an Emergency ____ Phone _________________________

Family Physician ____ Phone _________________________

INSURANCE INFORMATION:

Name of Insured ____ Birth Date ______________ Social Security # ______________________

Name and Address of Employer ____ Phone ________________________

Insurance Company Name and Address ____ Group # _______________________

GENERAL INFORMATION:

What is the reason for today's visit? ____

Do you have any questions or concerns we can help you with today? ____

Do you love your smile? ___________________ Is there anything you would like to change? ____

Why did you leave your last dentist? ____

MEDICAL HISTORY AND INFORMATION:

Do you have or ever had?

- ☐ Arthritis
- ☐ AIDS
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Heart problem
- ☐ Hepatitis __A __B __C
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaundice
- ☐ Kidney Problems
- ☐ Low Blood Pressure
- ☐ Rheumatic Fever
- ☐ Sexually Transmitted Diseases
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Other ____________________

Are you currently under the care of a physician? ☐ Yes ☐ No Please explain ____

Are you currently taking any medication? ☐ Yes ☐ No Please explain ____

Are you Allergic to? ☐ Aspirin ☐ Barbiturate ☐ Codeine ☐ Penicillin ☐ Other

Female Patients, are you Pregnant? ☐ Yes ☐ No If yes, due date ____

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.
I understand and agree that I am ultimately responsible for the balance on my account for any professional service rendered, regardless of insurance status. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or changes to the above information.

Signature ____ Date ___________________________

Parent or Guardian (if a minor) ____ Date ___________________________