TYGER RIVER FAMILY DENTISTRY

BRIAN K. ARMSTRONG, DMD

Patient's Name:______________________ Preferred Name:____________________ Martial Status:______

Address:____City:______________ Zip:___________

Date of Birth:________________ SS#________________ Home # ________________ Cell # ______________

Employer:__________________________ Business Phone: ____________________ Ext. ___________

Spouse's Name:__________________ Employer: ________________ Business Phone: _________________

****Who referred you to our practice?**________________________

MINOR PATIENTS: Parent/Guardian Name: ________________________ SS # ____________________

Parent/Guardian Employer: ________________________________Business Phone: ________________

In case of and Emergency: Contact Name: _______________________ Home Phone: __________________
Physician's Name: ________________ Phone Number: ____________ Pharmacy: _________ Phone #: ________

DENTAL INSURANCE INFORMATION

Carrier Name: ________________________ Insured's Name: ____________________ Insured's DOB ________
Policy/SS # Of Insured: __________________ Group Number: ______________ Phone Number: ____________

HEALTH /DENTAL HISTORY

Chief Dental Complaint: __________ Date of last dental visit: ________ Do you use tobacco? ________ Are you Pregnant? _____
Which month ? _____ Have you ever had any difficulties associated with dental treatment? _______ Are you allergic to or have had an allergic reaction to? Dental Anesthetics _____ Penicillin/Other Antibiotic ____ Other Drugs _____ Aspirin _____ Latex _____
Nickel _____ Has there been any change in your general health in the past 5 years? ______ Are you currently taking any medications? If so, please list medications:____

Please circle any of the following medical conditions you have or have had:

Rheumatic Fever	Heart Disease	Blood Disorders	Allergies	Tuberculosis	Kidney Problems
Heart Problems	Abnormal Bleeding	Seizures	Glaucoma	Diabetes	High Blood Pressure
Blood Transfusion	Epilepsy	Hepatitis	Aids/HIV Pos.	Heart Murmur	Stoke/Circulation Problems
Joint Replacement	Gland Problems	Heart Valve Problems	Stomach Ulcer	Angina	Radiation Treatment
Shortness Of Breath	Cancer/Tumor	Sex. Transmitted Dis.	Thyroid Problems	Prosthetic Joints	

Other:____

To the best of my knowledge , the provided medical/dental history is correct. I consent to such examinations, x-rays, and diagnostic procedures and test that may be prescribed. In addition, I consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of general or local anesthetic and indicated photos, and releasing information to my insurance company. I will assume responsibility for fees associated with any of the above.

Patient's (Parent/Guardian) Signature: ____ Date: ______________