Brickwalk DENTAL
FAMILY & COSMETIC DENTISTRY

1305 Post Rd Ste 200 Fairfield, CT 06824 P: 203.255.5999 F: 203.255.9972

About You

Patient Name _____ **Preferred Name** _____
Mr Mrs Ms Dr First MI Last
Birthdate _____ Age _____ ☐ Female ☐ Male ☐ Gender Neutral
SS# _____ ☐ Married ☐ Single ☐ Widowed ☐ Separated
Address _____ City _____ State _____ ZIP _____
Home # _____ Cell #_____ Email _____

How do you prefer to be contacted? ☐ Phone ☐ Text ☐ Email
How did you hear about us? ☐ Friend/Family ☐ Google ☐ Yelp ☐ Instagram ☐ Facebook ☐ Other
Who may we thank for referring you to the office? _____
Person to contact in case of emergency _____ Phone # _____
Person responsible for account _____ ☐ Self ☐ Spouse ☐ Parent ☐ Guardian
Family members seen by us _____

Patient's Employer _____ Address _____City _____
State _____ ZIP _____ Phone # _____ **Occupation** _____
Have you had a work-related injury (Worker's Compensation)? ☐ Yes ☐ No

For Insurance purposes
Name of Policy Holder _____ Birthdate _____ Relation _____
SS # _____ Policy Holder's Employer _____
Insurance Company _____ Group # _____ ID # _____

Dental & Medical History

Previous dentist _____ Date of last visit _____ Date of last x-rays _____
How often do you brush? _____ How often do you floss? _____
Why are you visiting the dentist today? _____
Have you ever had a problem associated with previous dental work? _____
If you could change the appearance of your teeth, what would you change? _____

Please check mark any of the following which may apply to your oral health now or in the past:

❑ Sensitivity to hot or cold (please circle)	❑ Jaw pain	❑ Periodontal (gum) treatment
❑ Sensitivity when biting or chewing	❑ Grinding of teeth	❑ Bleeding gums
❑ Broken teeth or fillings	❑ Orthodontic (braces) treatment	❑ Sores or growths in mouth
Please list any other conditions:		

Do you have a personal physician? ☐ Yes ☐ No
Physician's Name _____Phone # _____ Date of last visit _____
What prescription or over the counter medications, vitamins or herbs are you taking? _____
_____

CONTINUED ON BACK

Are you taking blood-thinning medications including Aspirin, Coumadin or Warfarin? ❑ Yes ❑ No
Have you ever taken Fosamax or any bisphosphonates for Osteoporosis or bone loss related issues? ❑ Yes ❑ No
Do you ever wake up from sleep and feel short of breath? ❑ Yes ❑ No
Do you smoke or use any form of tobacco? ❑ Yes ❑ No
Do you need to **premedicate** with antibiotics before dental procedures? ❑ Yes ❑ No
For women : Are you taking birth control pills? ❑ Yes ❑ No / Are you pregnant? ❑ Yes, week #: _____ ❑ No

Please check mark any of the following which may apply to you now or in the past:

❑ Congenital heart disease	❑ High Blood Pressure	❑ Diabetes: type _____
❑ Artificial heart valve	❑ Glaucoma	❑ Osteoporosis
❑ Damaged heart valves	❑ Head injuries	❑ Arthritis
❑ Infective endocarditis	❑ Tuberculosis	❑ Rheumatic fever
❑ Artificial Joints	❑ Respiratory problems	❑ Rheumatism
❑ Heart disease	❑ Tumors	❑ Sinus trouble
❑ Heart murmur	❑ Stroke	❑ Epilepsy or Seizures
❑ Pacemaker	❑ Asthma	❑ Headaches or Migraines
❑ HIV infection/AIDS	❑ Mental/Nervous disorders	❑ Herpes/Fever blisters
❑ Excessive bleeding	❑ Radiation or Chemotherapy	❑ Venereal Disease
❑ Hepatitis: type _____	❑ Cancer	❑ Autoimmune Disease
❑ Liver disease	❑ Thyroid problems	❑ Penicillin allergy
❑ Kidney disease	❑ Anemia	❑ Codeine allergy
❑ Stomach problems	❑ Gastric Reflux/ulcers	❑ Latex allergy
Any other conditions, allergies or surgeries:		

Authorization and Consent

I understand the above information is necessary to provide dental care in a safe and efficient manner. I certify that the information provided above is accurate to the best of my knowledge. Should further information be needed, the Smile Esthetics Scottsdale staff has my permission to ask the respective health care provider or agency, who may release such information. I will notify the doctor or hygienist of any changes in my health care or medications.

Consent to Treatment
I hereby authorize doctors or designated staff to take x-rays, study models and other diagnostic aids deemed appropriate to make a thorough diagnosis. Upon such diagnosis, I authorize the dental providers to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital on any possible complication.

Release of Information
I authorize the release of any information relating to any claim to third party payers. I hereby authorize and request my insurance company to pay directly to the dentist or dental office insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I am aware that Smile Esthetics Scottsdale makes every effort to conform to HIPAA Privacy Regulations but that my health care information may be released in the course of coordination of treatment, obtaining payment and health care operations.

Photography Release
I authorize the dental office to take photographs of me or my dependents for identification and to help us better understand our current dental condition and treatment options. I agree that photographs may be shown to other patients, potential patients or doctors for educational purposes while our names and identifying information will be kept confidential**.**

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____