



**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  Glaucoma  Kidney Problems  
 AIDS  Heart Murmur  Low Blood Pressure  
 Artificial Joints  Heart problem  Rheumatic Fever  
 Asthma  Hepatitis \_\_A\_\_B\_\_C  Sexually Transmitted Diseases  
 Cancer  High Blood Pressure  Stroke  
 Diabetes  HIV Positive  Tuberculosis  
 Epilepsy  Jaundice  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 \_\_\_\_\_