

# Bouressa Dental Associates, S.C.

James J. Bouressa, D.D.S.  
Michael J. Bouressa D.D.S.

Patient's Full Legal Name \_\_\_\_\_ Nick Name \_\_\_\_\_

If Child, Parent's Name \_\_\_\_\_

Patient's Date of Birth \_\_\_\_\_ Home Telephone \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Place of Employment \_\_\_\_\_ Work Telephone \_\_\_\_\_ Ext. \_\_\_\_\_

Person Responsible for Account \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

If applicable, please complete the following:

Name of Dental Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_

Name of Medical Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_

Patient Social Security Number \_\_\_\_\_ Responsible Party Social Security Number \_\_\_\_\_

## Medical History

Your Physician's Name \_\_\_\_\_ Office Telephone \_\_\_\_\_

Date of last medical examination \_\_\_\_\_

Are you presently under a physician's care? .....Yes No

Are you presently taking any medication? .....Yes No

If yes, please list \_\_\_\_\_

Are you allergic to penicillin, codeine or other drugs? .....Yes No

List any other allergies \_\_\_\_\_

Do you have diabetes? Yes No Do any immediate family members have diabetes? Yes No Who? \_\_\_\_\_

Have you ever had any excessive bleeding requiring treatment?.....Yes No

Do you have a history of substance abuse?.....Yes No

Have you had liver infections, hepatitis or jaundice?.....Yes No

Have you been exposed to AIDS or V.D.?.....Yes No

Women – are you pregnant?.....Yes No

Please circle any of the following which you have had:

- |                       |                         |                           |
|-----------------------|-------------------------|---------------------------|
| Heart disease         | Artificial Heart Valve  | Congenital Heart Disorder |
| Heart Attack/Failure  | Heart Murmur            | Heart Pace Maker          |
| Mitral Valve Prolapse | Rheumatic Fever         | Stroke                    |
| Artificial Joint      | Abnormal Blood Pressure | Anemia                    |
| Arthritis             | Epilepsy or Seizures    | Nervous Disorders         |
| Tuberculosis          | Asthma                  | Infections                |
| Sinus Trouble         | Tumors or Growths       | Latex Allergy             |

## Dental History

What is the main purpose of your visit today? \_\_\_\_\_

How long since your last thorough dental examination? \_\_\_\_\_

How often do you have your teeth examined and cleaned? \_\_\_\_\_

When and how often do you brush your teeth? \_\_\_\_\_ Floss your teeth? \_\_\_\_\_

Does food wedge between certain teeth? \_\_\_\_\_

Do your gums bleed easily, feel tender or irritated? \_\_\_\_\_

Do you often get cold sores? \_\_\_\_\_

Do you usually have a local anesthetic for dental treatment? \_\_\_\_\_

Are there any other dental problems we should be aware of? \_\_\_\_\_

OVER PLEASE

**Bouressa Dental Associates, S.C.**

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**Assignment & Release**

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I authorize release of needed information to my insurance company for processing and payment of treatment rendered. I authorize payment of the dental benefits directly to Bouressa Dental Associates, S.C. I understand that I am responsible for all costs of treatment rendered by Bouressa Dental Associates, S.C., regardless of dental insurance.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

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\*You May Refuse to Sign This Acknowledgement\*

I, \_\_\_\_\_, have received a copy of Bouressa Dental Associates, S.C., Notice of Privacy Practices.

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**For Office Use Only**

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)

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