Michael W. Brumm DMD, CDT, FAACD
William C. Strupp Jr., DDS, FAACD
COSMETIC AND RESTORATIVE DENTISTRY
906 N. Belcher Road • Clearwater, FL 33765 • 727-799-1011

CONFIDENTIAL PATIENT INFORMATION

Date_____

NAME _____
Last First Middle
Current Address _____
City _____State _____ Zip _____
Permanent Address (if different)
City _____State _____Zip_____
Email address _____ Home Phone (____) _____
Cell Phone (____) _____ Work Phone (____) _____ Occupation_____
Place of Employment _____Work Address_____
Emergency Name/Contact_____

Preferred Method of Contact: ☐ Home ☐ Cell ☐ Work ☐ Email ☐ Text
Date of Birth _____ Height ___ ft. ___ in. Weight _____ lbs.
SS# _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Sex: ☐ Male ☐ Female
Person Responsible for Payment of Account:_____

☐ Self ☐ Guarantor Relationship _____
SPOUSE NAME _____
Address if different _____
City _____ State _____ Zip _____
Occupation _____
Whom may we thank for referring you?
_____
Has any family member been treated here? ▫ Yes ▫ No Relationship
_____
Why did you choose Dr. Strupp/Brumm?
_____
Reason for Visit: _____

DENTAL HEALTH: Please circle one: Excellent Good Fair Poor
Priority you give your teeth (1–10, 10 highest): 1 2 3 4 5 6 7 8 9 10

DENTAL INSURANCE
PRIMARY Carrier Insurance Company
_____
Mailing Address _____

Employee _____ SS# _____ Group # _____

SECONDARY Carrier Insurance Company

_____

Mailing Address _____

Employee _____ SS# _____ Group # _____

MEDICAL HEALTH: Excellent Good Fair Poor
Date of last complete physical _____
Physician Name & contact _____

Are you under a doctor's care now? ☐ Yes ☐ No If yes, reason:

_____
Please list any medications, pills or drugs you are taking:

_____
Please list any vitamins or herbs you are taking:

_____

Have you ever received a blood transfusion? ☐ Yes ☐ No When? _____
Are you pregnant? _____ Expected delivery date? _____

Are you subject to prolonged bleeding? ☐ Yes ☐ No
Do you smoke? _____ How many packs per day? _____
Daily liquids _____ Candy consumption per day _____

Are you allergic to: ☐ Penicillin ☐ Codeine ☐ Latex ☐ Local Anesthetics (list) _____

Other medications? _____

Other allergies _____

Please Circle if You Have or Have Had Any of the Following:
Heart Trouble High Blood Pressure Artificial Joints Unintentional Weight Loss Heart Murmur
Low Blood Pressure Stroke Cancer. Rheumatic Fever Diabetes Ulcers X-Ray or Cobalt
Treatment Congenital Heart Lesion Blood Disease Allergies Chemotherapy/Radiation
Artificial Heart Valve Hepatitis A B C Asthma Thyroid Disease/Parathyroid
Heart Pacemaker Liver Disease Fainting or Dizziness Arthritis Gout
Heart Surgery Anemia Hay Fever Glaucoma
Chest Pain Sinus Trouble Emphysema Epilepsy or Seizures
Mitral Valve Prolapse Hypoglycemia Frequent Cough Alzheimer's Disease
Shortness of Breath Hemophilia Lung Disease Psychiatric Care
Swelling of Feet/Ankles/Hands Kidney Trouble Acid Reflux

Other serious illness or condition affecting dental treatment? ☐ Yes ☐ No
Details:

_____
_____

I will allow Drs. Strupp/Brumm to photograph/video record and use for educational or promotional purposes any aspect of my dental conditions or treatment procedures, and to publish such photographs/videos and any testimonials I provide. I further permit Drs. Strupp/Brumm to discuss my conditions/treatment with my physicians, referral doctors and other dental professionals either verbally or in writing by any means including but not limited to electronic transmission such as fax or non-encrypted email. They may also request any relevant medical information from my physicians they deem necessary for my dental treatment. A finance charge of 18% per year will be added to any account that is delinquent and Patient and Guarantor shall be jointly and severally liable for all reasonable costs and expenses (including, without limitation, reasonable attorneys' fees) incurred by the Dental Practice in collecting any past due amounts. Payment is due when services are rendered unless other arrangements have been made.

ACKNOWLEDGED AND ACCEPTED BY:

Patient's Signature _____ Date _____
Print Name:
_____

Guarantor's Signature _____Date _____

Print Name: _____