HEATHER J BROWN, DDS FAMILY DENTISTRY

CONFIDENTIAL PATIENT INFORMATION

PATIENT INFORMATION

Patient's Name ______________________________ Date ______________
First MI Last

Address ______________________ City ______________ State ________ Zip ______

Birth Date ______________________

Cellular # ______________ Work # ______________ Home # ______________

Email ______________

Person to Contact in Case of an Emergency ______________________ Phone ______________

RESPONSIBLE PARTY - - IF PATIENT IS A MINOR

Person Responsible for This Account ______________________ Relationship to Patient ______
First MI Last

Address ______________________ City ______________ State ________ Zip ______

Birth Date ______________________

Cellular # ______________________ Work # ______________ Home # ______________

Employer ______________________________________

INSURANCE INFORMATION

Name of Insured ______________________________ Relationship to Patient ______
First MI Last

Birth Date ______________

Name of Employer ______________________ Work Phone ______________________

Business Address ______________________ City ______________ State ________ Zip ______

Insurance Company ______________________ Member ID ______________ Group ID ______________

Please provide us with your insurance identification card

If I have dental insurance I authorize and request my insurance company to pay directly to Heather Brown, DDS Family Dentistry insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less then the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or that of my dependents.

X ______________________________ Date ______________
Signature of Patient or Parent/Guardian if Patient is a Minor

REGISTRATION

HEATHER J BROWN, DDS FAMILY DENTISTRY

CONFIDENTIAL HEALTH & DENTAL HISTORY

Patient's Name____ When Was Your Last Dental Visit ? ________________

Previous Dentist (Name and Location) ____

Please List All Medications You Are Currently Taking ____

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Are You Allergic to Any Medications? ❑ Yes ❑ No If Yes, Please List ____

ALLERGIC REACTIONS

Are You Allergic to Had Reactions To:

	Yes	No
Local Anesthetics Like Novocain?..........................	❑	❑
Penicillin or Other Antibiotics?..............................	❑	❑
Sulfa Drugs?	❑	❑
Barbiturates, Sedatives, Sleeping Pills?	❑	❑
Aspirin?..	❑	❑
Iodine?...	❑	❑
Metals like Nickel, Mercury, etc.?..........................	❑	❑
Latex / Rubber?..	❑	❑

Other (please list) ____

HEALTH AND DENTAL HISTORY

	Yes	No
Do Your Gums Bleed While Brushing or Flossing?	❑	❑
Are Your Teeth Sensitive to Hot or Cold?	❑	❑
Do You Feel Pain in Any of Your Teeth?	❑	❑
Have You Had Any Head, Neck or Jaw Injuries?	❑	❑
Do You Experienced "Jaw Clicking"?......................	❑	❑
Do You Have Pain in Your Jaw, Ear or Side of Face? ..	❑	❑
Any Difficulty Opening or Closing Your Jaw?	❑	❑
Any Difficulty Chewing?......................................	❑	❑
Do You Have Frequent Headaches?........................	❑	❑
Do You Bite Your Lips or Cheeks Frequently?...........	❑	❑
Have You Noticed Any Loosening of Your Teeth?	❑	❑
Does Food Tend to Get Caught Between Your Teeth?	❑	❑
Have You Ever Had Gum (Periodontal) Treatment? ..	❑	❑
Have You Ever Worn a Bite Plate or Other Appliance?	❑	❑
Have You Ever Had a Difficult Extraction in the Past?	❑	❑
Do You Clench or Grind Your Teeth?	❑	❑
Are You in Good Health?.................................	❑	❑
Do You Have High Blood Pressure?	❑	❑
Any Changes in Your Health over The Last Year?......	❑	❑

	Yes	No
Do You Have a Family Physician?..........................	❑	❑

Physicians Name ____

Physicians Address ______________________________________

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	Yes	No
Do You Bruise Easily?..	❑	❑
Have You Had Any Abnormal Bleeding?..................	❑	❑
Have You Had a Recent Weight Loss?	❑	❑
Have You Ever Taken Fen-Phen/Redux?.................	❑	❑
Are You Wearing Contact Lenses?.........................	❑	❑
Do You Use Tobacco?	❑	❑
Have You ever Required a Blood Transfusion?	❑	❑
Do You or Have You Used Controlled Substances?	❑	❑
Do You Have a Persistent Cough?	❑	❑

Women Only

	Yes	No
Are You Pregnant or Think You May Be Pregnant?	❑	❑
Are You Nursing?	❑	❑
Are You Taking Birth Control Pills?	❑	❑

Do You Have or Ever Had:

	Yes	No
Rheumatic Heart Disease or Rheumatic Fever?	❑	❑
Diabetes?	❑	❑
Heart Defect or Heart Murmur?	❑	❑
Are You Taking Coumadin, Plavix, Any Blood Thinner?	❑	❑
Heart Trouble, Disease, Heart Attack, or Angina?	❑	❑
Shortness of Breath?	❑	❑
Pacemaker?	❑	❑
Heart Surgery?	❑	❑
Congenital Heart Problem?	❑	❑
Swelling of Your Feet, Ankles or Hands?	❑	❑
Hepatitis, Jaundice, or Liver Disease?	❑	❑
Stroke?	❑	❑
Sinus Trouble?	❑	❑
Lung or Breathing Problems?	❑	❑
Asthma?	❑	❑
Hives or Skin Rash?	❑	❑
Nervousness?	❑	❑
Tumors?	❑	❑
Cortisone or Other Steroid Treatment?	❑	❑
Fever Blisters?	❑	❑
Scarlet Fever?	❑	❑
Hypoglycemia?	❑	❑

	Yes	No
Fainting or Dizzy Spells?	❑	❑
Eating Disorders?	❑	❑
Aids or HIV Infection?	❑	❑
Thyroid Problems?	❑	❑
Allergies?	❑	❑
Arthritis or Rheumatism?	❑	❑
Joint Replacement or Implant?	❑	❑
Stomach Ulcer?	❑	❑
Kidney Problems?	❑	❑
Tuberculosis?	❑	❑
Persistent Cough?	❑	❑
Cough That Produces Blood?	❑	❑
Chemotherapy (Cancer, Leukemia)?	❑	❑
Sexually Transmitted Disease?	❑	❑
Epilepsy?	❑	❑
Anemia?	❑	❑
Glaucoma?	❑	❑
Mental Health Care?	❑	❑
Back Problems?	❑	❑
Mitral Valve Prolapse?	❑	❑
Do You Have any Medical Condition Not Listed?	❑	❑

If Yes Please List ____

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Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered.

I understand that providing incorrect information can be dangerous to my health.

I authorize Dr. Heather Brown to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of dental care to third party payors and/or health practitioners

X ____________________________________ Date _____________

Signature of Patient or Parent/Guardian if Patient is a Minor