CONFIDENTIAL

MEDICAL HISTORY

Date _____ SS/HIC/Patient ID# _____

Patient Name _____ Date of Birth _____

Check (✓) if you have or have had problems with any of the following:

AIDS/HIV Positive	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Neurological Problems	☐ Yes ☐ No
Allergies	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Endocarditis	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Fibromyalgia	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Asthma or Hay Fever	☐ Yes ☐ No	Heart Attack	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
		Hemophilia	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Hepatitis Type _____	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Cancer Therapy	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Claustrophobia	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No		
Contact Lenses	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
COPD	☐ Yes ☐ No	Measles or mumps	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Nasal Obstruction	☐ Yes ☐ No		

Medications routinely used in dental treatment may interact with both prescription and a number of illegal street drugs. Check (✓) the medications you are presently taking, medications you have taken in the past, or medications you have had an adverse reaction to:

	Presently Taking	Taken in the Past	History of Reaction
Anesthetics, Locally Injected	☐	☐	☐
Anesthetics, General	☐	☐	☐
Antacids	☐	☐	☐
Anti-anxiety Medications	☐	☐	☐
Anti-depressants	☐	☐	☐
Antihistamines	☐	☐	☐
Daily Aspirin Regimen	☐	☐	☐
Birth Control Pills	☐	☐	☐
Blood Pressure Medications	☐	☐	☐
Codeine, Demerol or Other Analgesics	☐	☐	☐
Cortisone or Other Steroids	☐	☐	☐
Coumadin, Heparin, Warfarin or other blood thinners	☐	☐	☐
Dilantin	☐	☐	☐
Diuretics (water pills)	☐	☐	☐
Fen-phen (Ionimin, adipex, Fastin, phentermine, Pondimin, fenfluramine, Redux, dexfenfluramine)	☐	☐	☐
Heart Medications such as Digoxin, Nitroglycerin or Digitalis	☐	☐	☐
Ibuprofen (Motrin)	☐	☐	☐
Insulin or Diabetes Medications	☐	☐	☐
Sedatives or Tranquilizers	☐	☐	☐
Sleeping Pills (Barbiturates)	☐	☐	☐
Thyroid Medication such as Synthroid, Levoxyl or Levothyroxine	☐	☐	☐
Tylenol (Acetomeniphen)	☐	☐	☐
Adverse reaction to any other medication or drug	☐ Yes ☐ No		

Please specify _____

List the other medications you are currently taking and what condition you are taking them for. Include vitamins, supplements, herbs and over the counter medications.

Medication	Condition	Prescribing Doctor

Pharmacy Name _____ Phone ( ) _____

Women: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Have you had any serious illnesses or surgeries? ☐ Yes ☐ No If yes, describe _____

Check (✓) your current use of:

Tobacco ☐ Yes ☐ No
Packs per day _____
Alcohol, Beer, Wine ☐ Yes ☐ No
Drinks per day _____
Street Drugs ☐ Yes ☐ No
Times per day _____
Caffeine ☐ Yes ☐ No
Cups per day _____
High Stress ☐ Yes ☐ No
Reason _____

Do you have any other health needs you should bring to our attention? _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

WELCOME

one ABOUT YOU

Today's Date: ____/____/____ File #: _____

Patient Name: _____ _____ _____
LAST FIRST MI

What You Prefer To Be Called: _____ ❑ Male ❑ Female

Birthdate: ____/____/____ Age: _____ SS#: _____

Mailing Address: _____

_____ _____ _____
CITY STATE ZIP

Home Phone #: (_____) _____

Work Phone #: (_____) _____ Ext: _____

Cell Phone #: (_____) _____

E-mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

_____ _____ _____
CITY STATE ZIP

Occupation: _____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: _____

Do you have children? ❑ Yes ❑ No How many? _____

two INSURANCE INFO

Primary Dental Insurance

Co. Name: _____

Address: _____

_____ _____ _____
CITY STATE ZIP

Phone #: (_____) _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____

Address: _____

_____ _____ _____
CITY STATE ZIP

Phone #: (_____) _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

three ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

_____ _____ _____
CITY STATE ZIP

SS #: _____

Drivers License #: _____

Work Phone #: (_____) _____

Payment method: ❑ Cash ❑ Check

_____ ____/____
❑ Credit Card - Enter card # above (if accepted)

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
Initials

four IN EVENT OF EMERGENCY

Whom should we contact? _____

Relation: _____

Home Phone #: (_____) _____

Work Phone #: (_____) _____

Cell Phone #: (_____) _____

Who is your Medical Doctor? _____

Medical Doctor's Phone #: (_____) _____

PLEASE CONTINUE ON BACK

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DENTAL INFORMATION

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation

Are you in pain? ❑ No ❑ Yes How Long? _____

Please indicate ☑ any of the following problems:

❑ Discomfort, clicking or popping in jaw. ❑ Lost/Broken Filling(s) ❑ Stained teeth
❑ Red, swollen or bleeding gums. ❑ Teeth grinding ❑ Locking Jaw
❑ Sensitive tooth, teeth or gums. ❑ Ringing in Ears ❑ Bad breath
❑ Blisters/Sores in or around the mouth. ❑ Broken/Chipped tooth

❑ Other: _____

Do you require pre-medication? ❑ Yes ❑ No ❑ Don't know

Previous Dentist: _____ ( ) _____
Name Phone#

Last Dental exam: ___/___/___ Last Dental X-rays: ___/___/___

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Times a day you brush? _____ Times a week you floss? _____

What type of tooth brush bristles do you use? ❑ Soft ❑ Medium ❑ Hard

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

MEDICAL HISTORY

What medications are you taking? ❑ **Nerve pills** ❑ **Pain killers** (including aspirin) ❑ **Muscle relaxers**
❑ **Stimulants** ❑ **Blood Thinners** ❑ **Tranquilizers** ❑ **Insulin** ❑ **Meds for Osteoporosis**
❑ **Other(s), please list:** _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	**Y N** Thyroid Problems	**Y N** Cancer/Tumors	**Y N** Cosmetic Surgery
Y N Heart Surg./Pacemaker	**Y N** Kidney Problems	**Y N** Shingles	**Y N** Xray or Cobalt Treatment
Y N Heart Murmur	**Y N** Liver Problems	**Y N** Hepatitis	**Y N** Chemotherapy
Y N Rheumatic Fever	**Y N** Respiratory Problems	**Y N** HIV+/AIDS/ARC	**Y N** Asthma
Y N Mitral Valve Prolapse	**Y N** Sinus Problems	**Y N** Arthritis/ Rheumatism	**Y N** Difficulty Breathing
Y N Artificial Valves	**Y N** Stomach Problems/Ulcers	**Y N** Artificial Bones/Joints	**Y N** Diabetes/Hypoglycemia
Y N Heart Disease	**Y N** Psychiatric Problems	**Y N** Emphysema	**Y N** Leukemia
Y N Congenital Heart Defect	**Y N** Venereal Disease	**Y N** Fainting/Seizures/Epilepsy	**Y N** Anemia
Y N Chest Pains	**Y N** Alcohol/Drug Abuse	**Y N** Severe/Frequent Headaches	**Y N** High/Low Blood Pressure
Y N Scarlet Fever	**Y N** Tuberculosis TB	**Y N** Frequent Neck Pain	**Y N** Bleeding Problems
Y N Nervousness	**Y N** Jaw Problems TMJ/TMD	**Y N** Back Problems	**Y N** Glaucoma

Please list any other surgeries or medical conditions you have or ever had: _____

Are you allergic to any of the following? ❑ Latex ❑ Penicillin / Amoxicillin ❑ Tetracycline ❑ Aspirin

❑ Dental Anesthetics ❑ Foods: _____ ❑ Others: _____

Do you use tobacco? ❑ No ❑ Yes/How used? _____ How much? _____ How long? _____

Please rate your general health from 1-10: _____ Do you wear contact lenses? ❑ Yes ❑ No

Have you ever taken the drug Phen-fen and or Redux? ❑ Yes ❑ No

For women: Are you taking Birth Control pills? ❑ Yes ❑ No How many children have you had? _____

Are you Pregnant? ❑ No ❑ Yes/How long? _____ Are you nursing? ❑ Yes ❑ No

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET.

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ _____ Date ___/___/___
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE
(OFFICE USE)

Initials _____ Date ___/___/___
Comments

Initials _____ Date ___/___/___
Comments

Initials _____ Date ___/___/___
Comments

Richard C. Brown D.D.S.

OFFICE FINANCIAL POLICY

Thank you for choosing Dr. Richard C. Brown as your Dental Health Provider

We are committed to your treatment being successful

The following is a statement of our financial policy please read carefully

CASH PAYING PATIENTS

* Payment is due at time of service
* We accept cash, check, American Express, Discover, Master Card, Visa
* A $25.00 Charge is incurred for returned checks

INSURANCE PATIENTS

* All co-pays and yearly deductibles are to be paid at time of service
* We will be happy to process your insurance claims for you
* Your insurance policy is a contract between you and the insurance company
* Please be aware that some or all procedures may not be covered under your policy
* You are responsible for any balance not paid by your insurance company

MINOR PATIENTS

* The adult accompanying the minor is responsible for payment or co-payment at time of service.

MISSED APPOINTMENTS

* Please call our office 24 hours in advance to cancel an appointment
* There will be a charge of $35.00 per hour for missed appointments

I have read and understand the above financial policy

_____ _____

Signature **Date**

Richard C. Brown D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I have received a copy of the "Office's Notice of Privacy Practices"

*

Signature **Date**

ACKNOWLEDGEMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET

I have received a copy of the "Dental Material Fact Sheet" dated October 2001

*

Signature **Date**

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice and Dental Material Fact Sheet, 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 _____