Brace Family Dentistry

Michael L. Brace D.D.S.

We warmly welcome you to our office. Please take a few moments to complete the following information so we can better care for you. It is our goal to help you reach and maintain maximum oral health.

Name:____ I prefer to be called:____

Male Female Birth Date:__________________________ Social Security Number:_______________________________________

Home Address:____ City/Zip____

Home Phone_______________________________ Work Phone:___________________________ Cell:______________________

Along with phone confirmation we can also remind you of your appointment via E-mail. If you would like to be notified through E-mail also please provide your E-mail address:____

Whom may we thank for referring you:_______________________ Other family members seen by us?____________________________

Primary Dental Insurance

Insurance Co. Name:___________________________________ Insurance Co. Phone #:____________________________________

Insurance Co. Address__________________________________ Insured's Name:____

Insured's Birth Date:____________________________________ Insured's S.S. #:____

Name of Employer:____

Secondary Dental Insurance

Insurance Co. Name:___________________________________ Insurance Co. Phone #:____________________________________

Insurance Co. Address__________________________________ Insured's Name:____

Insured's Birth Date:____________________________________ Insured's S.S. #:____

Name of Employer:____

In the events of an emergency, please indicate someone who lives near you that we should contact:

Name:____ Phone:____

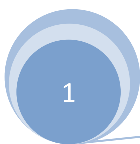
A note for our patients with dental insurance:

We will assist you in anyway possible to maximize your insurance benefits. We are happy to file claims to your insurance carrier if you desire. We will do our best to make as close of calculation as possible of what your insurance plan will cover, however regardless of what your insurance plan pays for you, you are responsible for all fees.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

____

Patient/Parent Signature Date



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Health History

Date of last health care exam:___________________________ What was this exam for?_______________________________

Have you been hospitalized in the last 5 years? (please circle) No Yes

If yes, reason:____

Are you currently receiving care? No Yes If yes, nature of care:____

Please list all names and phone number of the physicians who are currently providing you with care:__________________________

____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you may be asked some questions about your response. Our team may ask additional questions concerning your health.

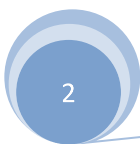
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Hemophilia	No	Yes
Anemia or Blood Disorder	No	Yes	High Blood Pressure	No	Yes
Anaphylaxis	No	Yes	H.I.V. Infection/AIDS or ARC	No	Yes
Angina	No	Yes	Irregular Heartbeat	No	Yes
Arthritis, Rheumatism or other inflammatory Disease?	No	Yes	Joint Replacement? When Placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Blood Disease	No	Yes	Liver Disease	No	Yes
Blood Transfusion	No	Yes	Low Blood Pressure	No	Yes
Breathing Problem	No	Yes	Lung Disease	No	Yes
Bruise Easily	No	Yes	Mitral Valve Prolapse	No	Yes
Cancer or Tumor	No	Yes	Parathyroid Disease	No	Yes
Chest Pains	No	Yes	Pre-Medication prior to dental appt?	No	Yes
Congenital Heart Disease	No	Yes	Radiation or Chemotherapy	No	Yes
Convulsions	No	Yes	Renal Disease	No	Yes
Diabetes	No	Yes	Rheumatic Fever	No	Yes
Easily Winded	No	Yes	Scarlet Fever	No	Yes
Emphysema	No	Yes	Shingles	No	Yes
Epilepsy	No	Yes	Slow-Healing Mouth Sores	No	Yes
Excessive Bleeding	No	Yes	Sickle Cell Disease	No	Yes
Excessive Thirst	No	Yes	Sinus Trouble	No	Yes
Fainting or Dizzy Spells	No	Yes	Stomach/Intestinal Disease	No	Yes
Frequent Cough	No	Yes	Stroke	No	Yes
Frequent Headaches	No	Yes	Swelling of Limbs	No	Yes
Glaucoma	No	Yes	Tonsillitis	No	Yes
Hay Fever	No	Yes	Tumors or Growths	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Ulcers	No	Yes
Heart Murmur	No	Yes	Venereal Disease	No	Yes
Heart Pace Maker	No	Yes	Tuberculosis	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes			

Please list any medications you are currently taking and dosages:

1.____ 2.____

3.____ 4.____

5.____ 6.____



Women:

Are you pregnant?	No	Yes	If no, are you planning a pregnancy in the near future?	No	Yes
Are you a nursing mother?	No	Yes	Are you taking birth control pills?	No	Yes

Are you allergic or have you had a reaction to:

Local anesthetics	No	Yes	Penicillin or other antibiotics	No	Yes
Aspirin, Ibuprofen or Tylenol	No	Yes	Codeine, Valium or other sedatives	No	Yes
Latex or Metals	No	Yes	Other (please specify)	No	Yes

Tobacco, Alcohol, Drugs

Do you use Tobacco	No	Yes	If yes, circle type:	Smoke	Chew
How much per day? ____________			For How long?		
Do you want to quit?	No	Yes			
Do you consume alcohol	No	Yes	If yes, approximately how many beverages per week?		
Do you use any mood altering drugs?	No	Yes	If yes, please name		

Dental History

Why have you come to the dentist today?____

Are you currently in pain or discomfort with your teeth and/or gums? No Yes

How would you describe the condition of your teeth and gums? Poor Fair Excellent

Previous/Present Dentist:____________________________ Phone Number:_________________

Last Visit Date:________________________________

Do your gums bleed?	No	Yes	Have you ever been told you have gum disease?	No	Yes
Do you grind or clench your teeth?	No	Yes	Have you ever had pain/discomfort in your jaw joint?	No	Yes
Would you like to have whiter teeth?	No	Yes	Would you like to keep your natural teeth for as long as you live?	No	Yes
Would you like to have straighter teeth?	No	Yes	Are you unhappy with any silver or discolored fillings?	No	Yes
Do you have crowns or bridges that are unattractive or unnatural looking?	No	Yes	Do you sometimes feel uncomfortable with the appearance of your smile?	No	Yes
Do you have unattractive spaces between your teeth?	No	Yes	Do you often feels as if your breath is not as fresh as it could be?	No	Yes
Do you have acid reflex?	No	Yes	Have you experienced any unfavorable reaction from any previous dental treatment?	No	Yes