**HEATHER J BROWN, DDS FAMILY DENTISTRY**

# CONFIDENTIAL PATIENT INFORMATION

## PATIENT INFORMATION

Patient's Name _____ Date _____
First MI Last

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____ Work Phone _____

Email _____

Preferred Method of Contact: ❑ Text / ❑ Home Phone / ❑ Cell Phone / ❑ Work Phone / ❑ Email

Social Security # _____ Birth Date _____

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 _____

Cell Phone _____ Home Phone _____ Work Phone _____

Social Security # _____ Birth Date _____

Employer _____ Work Phone _____

## INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____
First MI Last

Insured's Social Security # _____ Birth Date _____

Name of Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group Id _____ Member 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 ? _____

Please List the Prescription and Non-Prescription Medications You Are Currently Taking _____

_____

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

Previous Dentist (Name and Location) _____

If You Could Change Anything About Your Smile What Would You Change? _____

_____

## 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? | ❑ | ❑ |

| | Yes | No |
|---|---|---|
| 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 Wear Dentures or Partials? | ❑ | ❑ |
| Have You Ever Received Oral Hygiene Instructions? | ❑ | ❑ |
| Do You Clench or Grind Your Teeth? | ❑ | ❑ |

## MEDICAL HISTORY

| | Yes | No |
|---|---|---|
| Are You in Good Health? | ❑ | ❑ |
| Do You Have High Blood Pressure? | ❑ | ❑ |
| Any Changes in Your Health Over The Last Year? | ❑ | ❑ |
| Do You Have a Family Physician? | ❑ | ❑ |

Physicians Name _____

Physicians Address _____

_____

| | | |
|---|---|---|
| Do You Bruise Easily? | ❑ | ❑ |
| Have You Had Any Abnormal Bleeding? | ❑ | ❑ |
| Have You Had a Recent Weight Loss? | ❑ | ❑ |
| Have You Ever Taken Fen-Phen/Redux? | ❑ | ❑ |

| | Yes | No |
|---|---|---|
| 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? | ❑ | ❑ |
| Do You Have any Disease, Condition or Problem Not Listed That You Think I Should Know About? | ❑ | ❑ |

**Women Only**

| | | |
|---|---|---|
| Are You Pregnant or Think You May Be Pregnant? | ❑ | ❑ |
| Are You Nursing? | ❑ | ❑ |
| Are You Taking Birth Control Pills? | ❑ | ❑ |

| **Do You Have or Ever Had** (please answer carefully): | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Rheumatic Heart Disease or Rheumatic Fever? | ❑ | ❑ | Fainting or Dizzy Spells? | ❑ | ❑ |
| Diabetes? | ❑ | ❑ | Eating Disorders? | ❑ | ❑ |
| Heart Defect or Heart Murmur? | ❑ | ❑ | Aids or HIV Infection? | ❑ | ❑ |
| Are You Taking Coumadin, Plavix, Any Blood Thinner? | ❑ | ❑ | Thyroid Problems? | ❑ | ❑ |
| Heart Trouble, Disease, Heart Attack, or Angina? | ❑ | ❑ | Allergies? | ❑ | ❑ |
| Shortness of Breath? | ❑ | ❑ | Arthritis or Rheumatism? | ❑ | ❑ |
| Pacemaker? | ❑ | ❑ | Joint Replacement or Implant? | ❑ | ❑ |
| Heart Surgery? | ❑ | ❑ | Stomach Ulcer? | ❑ | ❑ |
| Chest Pain? | ❑ | ❑ | Kidney Problems? | ❑ | ❑ |
| Congenital Heart Problem? | ❑ | ❑ | Tuberculosis? | ❑ | ❑ |
| Swelling of Your Feet, Ankles or Hands? | ❑ | ❑ | Persistent Cough? | ❑ | ❑ |
| Hepatitis, Jaundice, or Liver Disease? | ❑ | ❑ | Cough That Produces Blood? | ❑ | ❑ |
| Stroke? | ❑ | ❑ | Chemotherapy (Cancer, Leukemia)? | ❑ | ❑ |
| Sinus Trouble? | ❑ | ❑ | Sexually Transmitted Disease? | ❑ | ❑ |
| Lung or Breathing Problems? | ❑ | ❑ | Epilepsy? | ❑ | ❑ |
| Asthma? | ❑ | ❑ | Anemia? | ❑ | ❑ |
| Hives or Skin Rash? | ❑ | ❑ | Glaucoma? | ❑ | ❑ |
| Nervousness? | ❑ | ❑ | Mental Health Care? | ❑ | ❑ |
| Tonsillitis? | ❑ | ❑ | Back Problems? | ❑ | ❑ |
| Tumors? | ❑ | ❑ | Chemical Dependency? | ❑ | ❑ |
| Cortisone or Other Steroid Treatment? | ❑ | ❑ | Mitral Valve Prolapse? | ❑ | ❑ |
| Fever Blisters? | ❑ | ❑ | Other (please list)_____ | | |
| Scarlet Fever? | ❑ | ❑ | _____ | | |
| Hypoglycemia? | ❑ | ❑ | | | |

## ALLERGIC REACTIONS

| **Are You Allergic to Had Reactions To:** | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Local Anesthetics Like Novocain? | ❑ | ❑ | Iodine? | ❑ | ❑ |
| Penicillin or Other Antibiotics? | ❑ | ❑ | Metals like Nickel, Mercury, etc.? | ❑ | ❑ |
| Sulfa Drugs? | ❑ | ❑ | Latex / Rubber? | ❑ | ❑ |
| Barbiturates, Sedatives, Sleeping Pills? | ❑ | ❑ | Other (please list)_____ | | |
| Aspirin? | ❑ | ❑ | _____ | | |

## 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

## DOCTOR'S COMMENTS _____

_____

_____

_____

X _____ Date _____
Signature: Dr. Heather J Brown

# HEALTH & DENTAL HISTORY

**HEATHER J BROWN, DDS FAMILY DENTISTRY**

# Acknowledgement of Receipt of Notice of Privacy Practices

**Purpose**: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I have received a copy of this Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

**For Office Use Only**

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)

_____

_____