Patient Legal Name_____Patient wants to be called _____

Address_____

City_____ST_____ZIP_____Home Phone_____

Cell Phone_____Work Phone_____e-mail_____

If applicable:

Parent/Guardian (with whom the patient lives)_____

PATIENT INFORMATION

Date of Birth____-_____-_____ Sex: Male [ ] Female [ ] SSN: _____-_____-_____

Marital: Single [ ] Married [ ] Divorced [ ] Widowed [ ]

Full Time Student [ ] Where_____

Occupation_____Employer_____
Address_____City_____ST____Zip_____Phone_____

ACCOUNT INFORMATION (Person to whom statement is to be mailed)
Responsible Person_____ SSN: _____-_____-_____
Date of Birth____-_____-_____ Phone Number (where you can be reached during the day)_____
Relationship to patient_____
Mailing Address_____City_____ST____Zip_____
Can we e-mail your statement [ ] yes [ ] no ***e-mail address***_____

INSURANCE INFORMATION
Primary Dental Insurance Company_____
Policy Holder_____ SSN: _____-_____-_____
Group #_____Member ID #_____
Employer _____Phone_____
City_____ST_____Zip_____

Secondary Dental Insurance Company_____
Policy Holder_____ SSN: _____-_____-_____
Group #_____Member ID #_____
Employer _____Phone_____
City_____ST_____Zip_____

Medical Insurance Company_____
Policy Holder_____ SSN: _____-_____-_____
Group #_____Member ID #_____
Employer _____Phone_____
City_____ST_____Zip_____

Whom may we thank for your referral?_____

MEDICAL and DENTAL HISTORY

Why have you come to the dentist today?

_____

Are you in pain now? [ ] yes [ ] no
Are your teeth sensitive to hot and cold? [ ] yes [ ] no
Are your teeth sensitive to air? [ ] yes [ ] no
Are your teeth sensitive to brushing? [ ] yes [ ] no
Are your teeth sensitive to sweets? [ ] yes [ ] no
Do your gums bleed? [ ] yes [ ] no
Do you like your smile? [ ] yes [ ] no
Have you ever taken Actenol or Boniva? [ ] yes [ ] no

Do you have a personal physican? [ ] yes [ ] no
Physican's Name:

_____

Physican's Address:

_____

Physican's City:
_____ST_____ZIP_____
Phone_____
Last Visit_____

For Women ONLY

Are you taking birth control pills? [ ] yes [ ] no
Are you pregnant? [ ] yes [ ] no
Week #_____
Are you nursing? [ ] yes [ ] no

Are you allergic to any of the following?

Y N Penicillin	Y N Tetracycline
Y N Aspirin	Y N Erythromycin
Y N Codiene	Y N Latex
Y N Dental Anesthetics	Y N Strawberries
Y N Kiwi	Y N Avocado

Please list any drugs that you are allergy to:

_____

Your current physical health is [ ] good [ ] fair [ ]poor
Are you currently under the care of a physican? [ ] yes [ ] no
Why?_____
Are you taking any prescription drugs? [ ] yes [ ] no
Are your taking any over the counter drugs? [ ] yes [ ] no
Have your taken any drugs within the last 48 hours? [ ] yes [ ] no
Please list each drug you are currently taking on the next page.

Have you ever had any of the following diseases or medical problems?

Y N Heart Attack/Stroke	Y N Psychiatric Problems
Y N Cancer/Chemotherapy	Y N Epilepsy/Seizures
Y N Heart Murmur	Y N Fainting Spells
Y N Mitral Valve Prolapse	Y N Diabetes
Y N Rheumatic Fever	Y N Tuberculosis
Y N HIV+/AIDS	Y N Drug/Alcohol Use
Y N Heart Surgery/Pacemaker	Y N Venereal Disease
Y N Shingles	Y N Hemophilia
Y N Kidney Problems	Y N Anemia
Y N Artificial Bones/Joints	Y N Sickle Cell Disease
Y N Artificial Valves	Y N Radiation Treatment
Y N Sinus Problems	Y N Asthma
Y N High Blood Pressure	Y N Arthritis
Y N Low Blood Pressure	Y N Difficulty Breathing
Y N Fever Blisters	Y N Hepatitis
Y N Blood Transfusion	Y N Liver Problems
Y N Emphysema	Y N Thyroid Condition
Y N Lupus	Y N Glaucoma
Y N Shortness of Breath	Y N Chest Pains
Y N Blood Disease	Y N Nervous Disorder
Y N Sleep Problems/Insomnia	Y N Spastic Colon
Y N Ulcers	Y N Depression
Y N Hayfever	Y N Whiplash Injury
Y N Multiple Sclerosis	Y N Gout
Y N Smoke/Tobacco Use	
Y N Severe/Frequent Headaches	

Have you ever been advised to take premedication prior to dental procedures? Y N Why? _____

I/We, the undersigned, authorize treatment to be rendered, and assume all financial responsibility.

A. I hereby authorize the performance of any dental or surgical procedures under the type of local anesthesia which may be advised or recommended by Brooks Dental Associates. I consent to any x-ray examination, laboratory procedure, local anesthesia, or dental treatment rendered under the general and special instructions of Dr C Paschal Brooks, Dr Charles P Brooks or any associate of Brooks Dental Associates. I understand that I have the option to request the use of a rubber dam, if I do not request the use of a rubber dam: it is understood that I give my permission to proceed with dental treatment without the use of a rubber dam

B. It is understood that all records, appliances, models, radiographs and photographs taken in and during the examination and treatment remain the property of Brooks Dental Associates.

C. Consent is hereby given to the taking and use of all the above for scientific and/or educational purposes.

D. I understand that the staff of Brooks Dental Associates will file my insurance as a courtesy to me. I understand that certain charges for professional services may not be covered in full by my insurance. I understand that all deductibles, and/or a percentage of the fees charged are due and payable at the time service is rendered. If my insurance is denied for any reason, I understand that payment in full on my account is due immediately, unless other arrangements have been made in advance.

E. I acknowledge full responsibility for the payment of services provided and agree to pay at the time of service unless other arrangements have been made in advance. Brooks Dental Associates has my permission to run a credit check. Should I fail to fully comply with any financial arrangements, I agree that financial charges will be added to my account in the amount of 1.5% per month. I understand that if my account is taken before a collection agency or attorney for collection for any reason, I am responsible for all collection and/or attorney fees.

F. **The information that I have given today is correct to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my medical history**.

Patient_____Responsible Party_____Date_____