## BROWN FAMILY DENTISTRY Welcome to Brown Family Dentistry – Tell Us About Yourself

## **Patient Information**

Name:						
Last Preferred Name:		First		MI	Title _ □ Male	☐ Female
Marital Status:	□ Single □ Mar	ried	☐ Divorced	□ Widowed	☐ Separated	☐ Domestic Partner
Address:			City		State	Zip
SSN:				DOB:		
Home Phone:				Work Phone:		
Cell Phone:				Email Addres	s:	
Employer:				Occupation: _		
How did you hea	ar about our offic	e?				
Address:	St			*Address:		
•	stCell	-		•		Zip
Soc Sec#				*Soc Sec#		
Employer				*Employer		
Insurance-Prima	ary			Insurance-Se	condary	
Subscriber Name				Subscriber Na	ime	
Subscriber DOB				Subscriber DO	OB	
Subscriber SSN/I	D			Subscriber SS	N/ID	
Subscriber Emplo	oyer			Subscriber En	nployer	
Insurance Compa	ny Name			Insurance Cor	mpany Name	
Group Number: _				Group Numbe	er	

Do you have a family physician?	□ Yes □ No	
Physician's Name:		
Your current physical health is:	□ Poor	
Are you currently under the care of a p	□ Yes □ No	
Are you taking any medications?	□ Yes □ No	
Please list:		
Have you ever had any surgical proced	ures?   Yes  No	
Do you require antibiotics prior to dent		Туре
Conditions		
Yes No	Yes No	Yes No
□ □ Abnormal bleeding □ □ Alcohol/Drug Abuse □ □ Allergies □ □ Anemia □ □ Arthritis □ □ Arthritis □ □ Asthma □ □ Blood disease □ □ Blood thinners □ □ Cancer □ □ Congenital Heart Defects □ □ Diabetes □ □ Dizziness □ □ Dizziness □ □ Emphysema (COPD)   Allergies Yes No □ □ Aspirin	□ □ Epilepsy □ □ Excessive bleeding □ □ Facial Surgery □ □ Fainting Spells □ □ Fever Blisters □ □ Frequent Headaches □ □ Glaucoma □ □ Heart Attack/disease □ □ Heart Murmur □ □ Heart Surgery □ □ Hemophilia □ □ Hepatitis □ □ High Blood Pressure □ □ HIV/AIDS   Yes No □ □ Erythromycin	□ Joint Replacement           □ Kidney Disease           □ Liver Disease           □ Low Blood Pressure           □ Pace Maker           □ Psychiatric Problems           □ Radiation Treatment           □ Rheumatic Fever           □ Shingles           □ Sickle Cell Disease           □ Sinus Problems           □ Stroke           □ Thyroid Problems           □ Tuberculosis    Yes No
□ □ Codeine	□ □ Jewelry	□ □ Penicillin
□ □ Clindamycin	□ □ Latex	☐ ☐ Tetracycline
Do you smoke? □Yes □ No	How much?	
If Female, please answer: Are you pregnant? ☐ Yes ☐ No	If so, how many weeks?	
What is the reason for your visit today When was your last dental visit?		
How frequently do you brush your teet		
How frequently do you floss your teeth		
Do your gums bleed when you brush o		
Do you experience tooth sensitivity to		□ No
Are you currently in pain? ☐ Yes		
Do you grind your teeth?		
, ,		П Уоз. П №
Are any of your teeth loose or are you	concerned about any teeth loosening?	□ Yes □ No