

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

Patient Information

Name: _____

Preferred Name: _____
Last First MI Title
 Male Female

Marital Status: Single Married Divorced Widowed Separated Domestic Partner

Address: _____ City _____ State _____ Zip _____

SSN: _____ DOB: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Employer: _____ Occupation: _____

How did you hear about our office?

Spouse Parent Information (*If parent information, fill both name sections completely)

Name: _____ *Name: _____

Address: _____ *Address: _____

City _____ St _____ Zip _____ *City _____ St _____ Zip _____

Hm Ph _____ Cell _____ *Hm Ph _____ Cell _____

Soc Sec# _____ *Soc Sec# _____

Employer _____ *Employer _____

Insurance-Primary

Subscriber Name _____

Subscriber DOB _____

Subscriber SSN/ID _____

Subscriber Employer _____

Insurance Company Name _____

Group Number: _____

Insurance-Secondary

Subscriber Name _____

Subscriber DOB _____

Subscriber SSN/ID _____

Subscriber Employer _____

Insurance Company Name _____

Group Number _____

Medical/Dental History

Do you have a family physician? Yes No

Physician's Name: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician due to specific condition? Yes No

Are you taking any medications? Yes No

Please list: _____

Have you ever had any surgical procedures? Yes No

Please list: _____

Do you require antibiotics prior to dental procedure? Yes No Type _____

Conditions

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| Yes | No | Yes | No | Yes | No |
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Allergies

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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 teeth each day? _____

How frequently do you floss your teeth each week? _____

Do your gums bleed when you brush or floss? Yes No

Do you experience tooth sensitivity to cold or hot temperatures? Yes No

Are you currently in pain? Yes No

Do you grind your teeth? Yes No

Are any of your teeth loose or are you concerned about any teeth loosening? Yes No