Patients Name: Today's Date:

Patient DOB: How did you hear about us?

Home Address: Insurance Company:

 Subscribers Name:

Preferred Phone #: Subscribers DOB:

Email: Member ID/SSN: Group #:

Employer: Previous Dentist: Phone:

Occupation: Approx. Date of last Exam:

Emergency Contact: Reason for your visit: Routine Invisalign Clenching/grinding Pain

Relationship: Cell: Sleep Apnea Whitening Implants Cosmetic Other\_\_\_\_\_\_\_\_\_\_\_\_\_

**Women:** Pregnant? Y/N Trying to become pregnant? Y/N Nursing? Y/N Taking oral contraceptives? Y/N

**Allergies:** Aspirin: Y/N Penicillin: Y/N Codeine: Y/N Acrylic: Y/N Metal: Y/N Latex: Y/N Sulfa Drugs: Y/N Peanuts: Y/N

Are you under the care of a physician now? **Y or N** If so, why?

Please list all medications and vitamins:

Do you use controlled substances? **Y or N** If so, what?

Have you ever been hospitalized, or had a major operation? **Y or N** If yes, what/when?

Pharmacy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have or have you had any of the following?

Aids/HIV Pos. **Y or N**

Anaphylaxis **Y or N**

Anemia **Y or N**

Angina **Y or N**

Arthritis **Y or N**

Artificial Heart Valve **Y or N**

Artificial Joint **Y or N**

Asthma **Y or N**

Blood Disease **Y or N**

Blood Transfusion **Y or N**

Breathing Problems **Y or N**

Cancer **Y or N**

Chemotherapy **Y or N**

Chest Pains **Y or N**

Cold Sores **Y or N**

Heart Disorders **Y or N**

Jaundice **Y or N**

Diabetes **Y or N**

Drug Addiction **Y or N**

Emphysema **Y or N**

Epilepsy **Y or N**

Frequent Cough **Y or N**

Genital Herpes **Y or N**

Glaucoma **Y or N**

Hay Fever **Y or N**

Heart Attack **Y or N**

Heart Murmur **Y or N**

Pacemaker **Y or N**

Hepatitis **Y or N**

High Blood Pressure **Y or N**

High Cholesterol **Y or N**

Hypoglycemia **Y or N**

Kidney Problems **Y or N**

Leukemia **Y or N**

Liver Disease **Y or N**

Low Blood Pressure **Y or N**

Lung Disease **Y or N**

Mitral Valve Prolapse **Y or N**

Osteoporosis **Y or N**

Parathyroid **Y or N**

Mental Disorder **Y or N**

Radiation Treatment **Y or N**

Dialysis **Y or N**

Sinus Trouble **Y or N**

Spina Bifida **Y or N**

Stomach disease **Y or N**

Stroke **Y or N**

Tuberculosis **Y or N**

Is there any other health information not listed that Dr. Kelly Halle Brown should be made aware of before treating you?

If yes, please explain:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that by providing incorrect information, it can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any medical changes.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_

Update Date & Initial \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Update Date & Initial \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Update Date & Initial \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_