KEVIN BROWNE
DMD

MEDICAL HISTORY

PATIENT NAME________________________ DATE OF BIRTH________
ADDRESS____
MARITAL STATUS____________ CELL PHONE______________________
HOME PHONE__________________ WORK PHONE____________________
EMAIL ADDRESS____
SOCIAL SECURITY NUMBER_____________________________________

DO YOU HAVE OR HAVE YOU HAD:

ABNORMAL BLEEDING________
AIDS OR HIV______________
ARTIFICIAL HEART VALVES____
ARTIFICIAL JOINT OR PROTHESIS__________
BLOOD TRANSFUSION________
CANCER__________________
CHEMICAL DEPENDENCY_____

CHEMO THERAPY_______
DIABETES_____________
EPILEPSY OR SEIZURES________
HEART DISEASE_________
HEART MURMUR/ MVP___________
HEPATITIS____________

HIGH BLOOD PRESSURE________
LIVER PROBLEMS____
PACEMAKER_________
PSYCHIATRIC CARE___
RADIATION TX_______
TOBACCO HISTORY________

NOTES:____
____

ALLERGIES:

ANTIBIOTICS________
ANESTHETICS_______

CODEINE____
LATEX_____

PENICILLIN______
OTHER__________

CURRENT MEDICATIONS____

WHAT PROMPTED YOU TO COME AND SEE US?______________________

WHAT IS YOUR PRIMARY DENTAL HEALTH CONCERN?________________

HOW WOULD YOU RATE YOUR DENTAL HEALTH ON A SCALE 0—10.______________

DO YOU EVER EXPERIENCE TOOTH SENSITIVITY?__________________

DO YOUR GUMS BLEED OR HURT?________________________________

HAVE YOU NOTICED ANY MOUTH ODORS OR BAD TASTES?_____________

DO YOU GET FOOD CAUGHT BETWEEN TEETH?______________________________

HAVE YOU EVER HAD ORTHODONTIC TREATMENT (BRACES)?____________________________

HAVE YOU EVER SEEN A PERIODONTIST?______________________________

DO YOU HEAR CLICKING OR POPPING WHEN YOU OPEN OR CLOSE YOUR MOUTH?______________________________

DOES YOUR JAW GET TIRED WHEN YOU TALK OR EAT?________________________

DO YOU GET HEADACHES?______________________________________

DO YOU LIKE THE COLOR OF YOUR TEETH?______________________________

DO YOU LIKE THE APPEARANCE OF YOUR TEETH/SMILE?______________________
IF NO, WHAT WOULD YOU LIKE TO CHANGE?______________________________

DO YOU FEEL NERVOUS ABOUT HAVING DENTAL TREATMENT?
YES NO IF YES, WHAT IS YOUR BIGGEST CONCERN?______________________

WHAT IS MOST IMPORTANT TO YOU IN A DENTAL PRACTICE?____________________

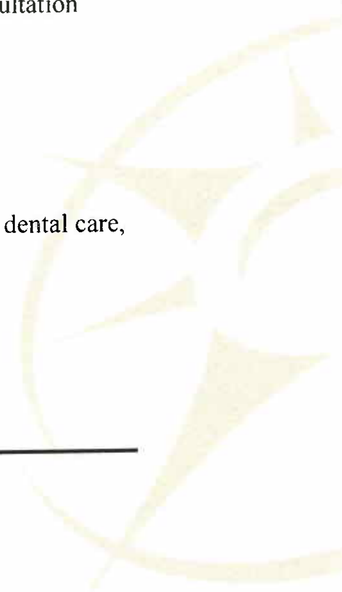
IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW?_____________________

Whom may we thank for referring you to our practice?______________________________

I acknowledge to you that I have been given the opportunity to ask questions about the examination, the procedures to be used and the risks involved however slight. I believe that I have sufficient information to give you my consent.

I also give you permission to share my health information with other health care professionals and dental specialists. This includes the release of my dental charts and records for the sole purpose of consultation regarding diagnosis, treatment planning and care.

Further, I give you permission to use my photographs for educational and marketing purposes.



PAYMENT AGREEMENT

With my signature below, I understand that I am fully responsible for all fees associated with my dental care, and that all fees are due at the time of service.

__________________________________ ________________

SIGNATURE DATE