KEVIN BROWNE
DMD

MEDICAL HISTORY

PATIENT NAME_____ DATE OF BIRTH_____
ADDRESS_____
TOWN_____
MARITAL STATUS_____ CELL PHONE_____
HOME PHONE_____ WORK PHONE_____
EMAIL ADDRESS_____
OCCUPATION_____

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_____
RADIATION TX_____
HEPATITIS_____
HIGH BLOOD PRESSURE_____
LIVER PROBLEMS____
PACEMAKER_____
PSYCHIATRIC CARE___
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._____

HAVE YOU EVER HAD ORTHODONTIC TREATMENT (BRACES)?_____

HAVE YOU EVER WORN A NIGHTGUARD OR APPLIANCE?_____

HAVE YOU EVER SEEN A PERIODONTIST?_____

29 South Street
New Providence, NJ 07974
(908) 286-1486
(908) 286-1444 Fax

... giving patients direction to optimal oral health

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?_____

HOW WOULD YOU RATE THE APPEARANCE OF YOUR SMILE ON A SCALE OF 0-10?_____

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