Browning Smile Design

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us—we will be happy to help.

Date______________________

SS#______________________

Patient Information (confidential)

Name____ Birthdate__________________Home#_____________________

Address____ City________________________ State_______ Zip___________

Email____ Cell #__________________________

Please circle: Minor Single Married Divorced Widowed Separated

If Student, Name of School/College:____________________City________________State________ Zip_______ FT / PTime

Patient or Parent/Guardian's Employer____Work#__________________

Spouse or Parent/Guardian's Name____________________Employer____________________Work#__________________

Whom may we thank for referring you? Friend/Family (name)____

Sign/Yellow Pages/Internet/Insurance Website/Neighborhood Newsletter/Magazine/Work in Vintage Park

Person to Contact in Case of Emergency____Phone_______________________

Responsible Party

Name of Person Responsible for this Account______________________________________Relationship________________

Address____Home #_____________________

Birthdate_________Driver's License #___________________SS#___________________Email_________________________

Employer____Work #_________________________Cell#_______________________

Is this Person Currently a Patient in our office? Yes No

Dental Insurance Information

Name of Insured____Relationship to patient____________________

Birthdate______________SS#/ID#__________________________________Date Employed____________________________

Name of Employer____Work #_____________________

Dental Insurance Company____________________________ Group#_________________Phone#______________________

Do you Have Additional Dental Insurance? Yes/ No If yes, please complete the following:

Name of Insured____Relationship to patient____________________

Birthdate______________SS#/ID#__________________________________Date Employed____________________________

Name of Employer____Work #_____________________

Dental Insurance Company____________________________ Group#_________________Phone#______________________

Patient Medical History

Y N Are you under any medical treatment now?
Y N Have you been hospitalized for any serious illness within the last 5 years?
If yes, explain_______________________________
____
Y N Are you taking any medication(s) or non-prescription medicine?
Which medication(s) are you taking?___________
____
Y N Do you use tobacco?
Y N Do you use controlled substances?
Y N Are you wearing contact lenses?
Y N Have you had any surgeries within the last 5 years?
If yes, explain_______________________________
____

Are you allergic to or ever had a reaction to the following?
Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Jewelry
Y N Latex
Y N Metals
Y N Penicillin
Y N Tetracycline
Y N Antibiotics
Y N Sulfa Drugs
Other____________________________________
Women Only:
Y N Are you pregnant or think you may be pregnant?
Y N Are you nursing?
Y N Are you taking oral contraceptives?

If you HAVE, or ever have experienced any of the following, please circle ALL that apply:

Y N High Blood Pressure
Y N Heart Attack
Y N Rheumatic Fever
Y N Swollen Ankles
Y N Fainting/Seizures
Y N Asthma
Y N Low Blood Pressure
Y N Epilepsy/Convulsions
Y N Leukemia
Y N Diabetes
Y N Kidney Diseases
Y N AIDS or HIV Infection
Y N Thyroid Problems
Y N Heart Disease
Y N Cardiac Pacemaker
Y N Heart Murmur
Y N Anemia
Y N Emphysema
Y N Cancer
Y N Arthritis
Y N Joint Replacement or Implant
Y N Hepatitis/Jaundice
Y N Sexually Transmitted Disease
Y N Stomach Trembles/Ulcers
Y N Chest Pains
Y N Easily Winded
Y N Stroke
Y N Hay Fever/Allergies
Y N Tuberculosis
Y N Radiation Therapy
Y N Glaucoma
Y N Recent Weight Loss
Y N Liver Disease
Y N Respiratory Problems
Y N Mitral Valve Prolapse
Y N Other________________
____

Patient's Height_____________ **Patient's Weight**______________

Patient Dental History

Date of your Last Dental Visit:____________________ Previous Dentist's name_____________________________________

Y N Do you ever bleed while brushing or flossing?
Y N Are your teeth sensitive to hot or cold liquids/foods?
Y N Are your teeth sensitive to sweet or sour liquids/foods?
Y N Do you feel pain to any of your teeth?
Y N Do you have any sores or bumps in or near your mouth?
Y N Have you had any neck, head, or jaw injuries?
Y N Have you ever experienced any of the following problems in your jaw?
- **Y N** Clicking
- **Y N** Pain (joint, ear, side of face)
- **Y N** Difficulty in opening or closing
- **Y N** Difficulty in chewing

Y N Do you have frequent headaches?
Y N Do you clench or grind your teeth?
Y N Do you bite your lips or cheeks frequently?
Y N Have you ever had any difficult extractions in the past?
Y N Have you ever had any prolonged bleeding after extractions?
Y N Have you ever had any orthodontic treatment?
Y N Do you wear dentures or partials?
If yes, date of placement___________________
Y N Have you ever received oral hygiene instructions regarding the care of your teeth and gums?
Y N Do you take any premeds before dental visits?
Y N Do you like your smile?

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services on my behalf or my dependents.

Signature____Date___________________________________