Lauren Brownfield, DDS, MS

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: ____

Preferred Name: _____

Patient is: ☐ Policy Holder ☐ Responsible Party

Responsible Party (if someone other than the patient):

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip Code: _____ Pager #: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec #: _____ Driver's Licence #: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information:

Address: _____ Address 2: _____

City: _____ State: _____ Zip Code: _____ Pager #: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: _____ Age: _____ Soc Sec #: _____ Driver's Licence #: _____

E-mail address: _____ ☐ I would like to receive correspondence via e-mail.

Section 2

Employment Status: ◯ Full Time ◯ Part Time ◯ Unemployed ◯ Retired

Student Status: ◯ Full Time ◯ Part Time ◯ None

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

Previous Dentist: _____

Emergency Contact: _____

Emergency Contact #: _____

PreMed Necessary?: _____

Primary Insurance information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Remaining. Benefits: _____ Remaining Deductible: _____

Secondary Insurance information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Remaining. Benefits: _____ Remaining Deductible: _____

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MEDICAL AND DENTAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Patient Name: _____ Date of Birth: _____

Are you under a physician's care now? ◯ Yes ◯ No If Yes, please explain: _____

Have you been hospitalized, had surgery, or anesthesia? ◯ Yes ◯ No If Yes, please explain: _____

History or family history of problems with anesthesia? ◯ Yes ◯ No If Yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If Yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If Yes, please explain: _____

Do you use tobacco? ◯ Yes ◯ No Packs per day: _____ # of years: _____

Do you drink alcohol? ◯ Yes ◯ No Drinks per week: _____

Do you use recreational drugs? ◯ Yes ◯ No

Are you on a special diet? ◯ Yes ◯ No _____

What do you take for headaches or pain? _____

Women, are you: Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ◯Yes ◯No	Drug Addiction ◯Yes ◯No	High Blood Pressure ◯Yes ◯No	Sinus Trouble ◯Yes ◯No
Anaphylaxis ◯Yes ◯No	Easily Winded ◯Yes ◯No	Hives or Rash ◯Yes ◯No	Sleep Apnea ◯Yes ◯No
Anemia ◯Yes ◯No	Emphysema ◯Yes ◯No	Hypoglycemia ◯Yes ◯No	Snoring ◯Yes ◯No
Arthritis/Rheumatism ◯Yes ◯No	Epilepsy or Seizures ◯Yes ◯No	Irregular Heartbeat ◯Yes ◯No	Stomach/Intestinal Disease ◯Yes ◯No
Artificial Heart Valve ◯Yes ◯No	Excessive Bleeding ◯Yes ◯No	Kidney Problems ◯Yes ◯No	Stroke ◯Yes ◯No
Artificial Joint ◯Yes ◯No	Excessive Thirst ◯Yes ◯No	Leukemia ◯Yes ◯No	Swelling of Limbs ◯Yes ◯No
Asthma ◯Yes ◯No	Fainting/Dizziness ◯Yes ◯No	Liver Disease ◯Yes ◯No	Thyroid Disease ◯Yes ◯No
Back Pain ◯Yes ◯No	Frequent Cough ◯Yes ◯No	Low Blood Pressure ◯Yes ◯No	Tonsilitis ◯Yes ◯No
Blood Transfusion ◯Yes ◯No	Frequent Diarrhea ◯Yes ◯No	Lung Disease ◯Yes ◯No	Tuberculosis ◯Yes ◯No
Breathing Problem ◯Yes ◯No	Frequent Headaches ◯Yes ◯No	Mitral Valve Prolapse ◯Yes ◯No	Tumors/Swelling ◯Yes ◯No
Bruise Easily ◯Yes ◯No	Glaucoma ◯Yes ◯No	Parathyroid Disease ◯Yes ◯No	Ulcers ◯Yes ◯No
Cancer ◯Yes ◯No	Heart Attack/Failure ◯Yes ◯No	Psychiatric Treatment ◯Yes ◯No	Venereal Disease ◯Yes ◯No
Chemotherapy ◯Yes ◯No	Heart Murmur ◯Yes ◯No	Radiation Treatments ◯Yes ◯No	
Chest Pains ◯Yes ◯No	Heart Pace Maker ◯Yes ◯No	Recent Weight Loss ◯Yes ◯No	
Cold Sores/Fever Blisters ◯Yes ◯No	Heart Trouble/Disease ◯Yes ◯No	Renal Dialysis ◯Yes ◯No	
Congenital Heart Disorder ◯Yes ◯No	Hemophilia ◯Yes ◯No	Rheumatic Fever ◯Yes ◯No	
Cortisone Medicine ◯Yes ◯No	Hepatitis A ◯Yes ◯No	Seasonal Allergies ◯Yes ◯No	
Depression ◯Yes ◯No	Hepatitis B or C ◯Yes ◯No	Shingles ◯Yes ◯No	
Diabetes ◯Yes ◯No	Herpes ◯Yes ◯No	Sickle Cell Disease ◯Yes ◯No	

Have you ever had any serious illness not listed above? If yes, please explain: _____

Dental History

What is your Chief Complaint? _____

Who is your Dentist? _____ Date of last dental cleaning? _____

Have you ever had periodontal care? ◯Yes ◯No If yes, when? _____ Have you ever had orthodontic care? ◯Yes ◯No If yes, when? _____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

Have you ever experienced any of the following?

☐ Bleeding gums ☐ Painful gums ☐ Receding gums ☐ Puss ☐ Loose teeth

☐ Spaces between teeth ☐ Drifting of teeth ☐ Bad breath ☐ Dry mouth

☐ Pain in jaw ☐ Clicking in jaws ☐ Grinding teeth ☐ Clenching teeth

Are any of your teeth sensitive to hot or cold, or when chewing? ◯Yes ◯No If yes, please explain? _____

How would you describe your previous dental experiences? _____

Are you aware that recent research has suggested that infected gums may increase the dangers associated with diabetes, heart disease, stroke, lung damage, and/or (a female) delivering a premature/low-bith-weight baby? ◯Yes ◯No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my resposibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN_____ DATE_____