Michelle P. Brown, D.D.S.
1401 Aversboro Road, Suite 202
Garner, NC 27529
Email: _____

Date: _____
Name: _____
Address: _____
_____
Home #: _____ Work #: _____
Cell #: _____ Best # to Reach You: _____
Birthdate: _____ SS #: _____
Employer: _____ Occupation: _____
Spouse's Name: _____
Birthdate: _____ SS #: _____
Employer: _____ Work #: _____

Medical/Health History:
Please list your family physician and any medical specialist you see at least once a year:
Name: _____ Practice Name: _____ Phone: _____
Name: _____ Practice Name: _____ Phone: _____
Are you currently under the care of a physician? (Please Circle)…….. YES NO
Are you in good health? (Please Circle) …….....……..... YES NO

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 medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Please answer the following questions as thoughtfully and thoroughly as possible.

1. Do you have (or have you ever had) any of the following?

YES NO A. Allergic Reaction to Drugs or Latex (Circle all that apply.)
Latex , Penicillin, Aspirin, Codeine, Local Anesthetics, Metal Other: _____
Please describe the type of reaction: _____

YES NO B. Heart Attack, Heart Disease, Or Stroke (please circle)

YES NO C. High Blood Pressure

YES NO D. Congestive Heart Failure

YES NO E. Angina (Chest Pains)

YES NO F. Irregular Heart Beats

YES NO G. Artificial Heart Valve

YES NO H. Rheumatic Fever, Rheumatic Heart Disease, Bacterial Endocarditis

YES NO L. Congenital Heart Disease YES NO J. Heart Murmur

YES NO K. Mitral Valve Prolapse

YES NO L. Immunosuppressive Condition (Circle All That Apply.)
Steroid therapy (e.g. Prednisone) Radiation or Cancer Therapy HIV
SLE (Lupus) Rheumatoid .Arthritis Organ Transplant Spleen Removed
Other: _____

YES NO M. Artificial Joint (s) (Circle all that apply and dates placed.)
Hip _____ Knee _____ Ankle _____Shoulder _____

YES NO N. Other artificial implants or devices

YES NO O. Bleeding Problems, anemia, or other blood disease

YES NO P. Diabetes

YES NO Q. Thyroid Disease
YES NO R. Nervous System Disease or Seizures
YES NO S. Kidney Disease
YES NO T. Hepatitis (A, B, C. or D) (Please Circle) or other Liver Disease
YES NO U. Muscle or Joint Disease or Arthritis (Osteo or Rheumatoid)
YES NO V. Asthma, Tuberculosis, or other Lung Disease
YES NO W. Stomach or Intestinal Disease
YES NO X. Mental Health Condition - Specify:_____
YES NO Y. Physical or Mental Disabilities that may require special care
YES NO Z. Impairment of Hearing, Sight, or Speech
YES NO AA. Are you or have you ever been treated for cancer?
YES NO BB. Are you or could you be pregnant? Are you nursing? _____ If Pregnant, Week _____
YES NO CC. Do you have any disease, condition, or problem not listed here?
Describe: _____
YES NO DD. Have you ever been hospitalized or had surgery?
Describe: _____
YES NO EE. Are you, or have you ever been addicted to a chemical substance?
YES NO FF. Do you currently use alcohol or recreational drugs?
YES NO GG. Do you smoke or use smokeless tobacco?
YES NO HH. What type of tobacco products do you use? _____
YES NO II. How interested are you in stopping your tobacco use? (Circle One)
Very Interested Somewhat Interested Not at all Interested
YES NO JJ. Do you regularly take herbal medicines or dietary supplements? Specifically _____
Please Circle all that apply:
Echinacea Garlic Ginger Kava Gingko Ginseng
St. John's Wort Vitamin E Fish Oil
YES NO KK. Have you undergone current or past osteoporosis therapy?
Examples: Fosamax, Actonei, Boniva

2. Please use the space below to list any prescription/ over the counter drugs that you are taking.

_____
_____
_____

DENTAL HISTORY:

YES NO 1. Do you have regular dental checkups? Date of Last Exam: _____
YES NO 2. Have you bad any trouble associated with previous dental treatment? If so, please explain:_____
YES NO 3. Have you noticed any lumps or sores in your mouth?
YES NO 4. Do your gums bleed when you brush?
YES NO 5. Have you ever injured your face, jaws, or teeth?
YES NO 6. Do you suffer from pain in your mouth, face, neck, eyes or throat?
YES NO 7. Are you happy with the appearance of your teeth?
YES NO 8. Do you want to save your teeth?
YES NO 9. Has fear ever prevented you from seeking dental treatment?
YES NO 10. Are you allergic to any metals or dental materials?

***** Please circle the types of dental treatment you have experienced.**

Braces Dentures Root Canal Treatment Implants Oral Surgery
Fillings Periodontal (Gum) Treatment TMJ treatment

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 health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature: _____Date: _____

Payment is due In MI at the time of treatment unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible format of services rendered and also responsible for paying co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature: _____ Date: _____

For Our Patients With Insurance, please answer the following:

Insurance Carrier: _____
Policy Holder's Name: _____
ID#: _____
Telephone # to Insurance Company: _____