Smiles by

Douglas M. Brown, D.D.S., M.S., Inc.
Orthodontics Exclusively

The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset.
Please fill out this form completely. The better we communicate, the better we can care for you.

1 About You

Today's Date: ______________________

Email Address: ______________________________________

Name: ______________________________________
LAST FIRST MI MR MRS MS DR

I prefer to be called: ________________ ☐ Male ☐ Female

Birthdate: ____/____/____ Age: _____ SS #:_______________

Home Address: ______________________________________
APT/CONDO #:

____
CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (_____) _____________ Cell/Other #: _____________

Wk #: (_____) _____________ Ext: ______

Employer: ______________________________________

Employer's Address: ______________________________

How long there? _______ Occupation: ________________

Where & when are best times to reach you? ______________

Whom may we thank for referring you? ________________

Other family members seen by us: ____________________

General Dentist: _________________________________

Last Visit Date: _________________________________

3 Orthodontic Insurance

Primary

Orthodontic Coverage:☐ Yes ☐ No Dental Coverage:☐ Yes ☐ No

Insurance Co. Name: ______________________________

Insurance Co. Address: ____________________________

Insurance Co. Phone #: (_____) ______________________

Group # (Plan, Local or Policy #): _____________________

Insured's Name: ____________________ Relation: _______

Insured's Birthdate: ___/___/___ Insured's SS#:____________

Insured's Employer: _______________________________

Secondary

Orthodontic Coverage:☐ Yes ☐ No Dental Coverage:☐ Yes ☐ No

Insurance Co. Name: ______________________________

Insurance Co. Address: ____________________________

Insurance Co. Phone #: (_____) ______________________

Group # (Plan, Local or Policy #): _____________________

Insured's Name: ____________________ Relation:_______

Insured's Birthdate: ___/___/___ Insured's SS#:____________

Insured's Employer: _______________________________

2 Spouse Information

His / Her Name: __________________________________

Employer: _______________________________________

Wk #: (_____) ____________Ext: _____ SS #:_____________

Birthdate: _____/_____/_____

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: ____________________ Relation: _______

Wk #: (_____) _____________ Hm#: (_____) _____________

Person Responsible For Account

Person Responsible for Account: ______________________

Wk #: (_____)___________Ext:_____ Hm#:(_____) _________

Billing Address: __________________________________

Relation: ____________________ SS #: _______________

Employer: _______________________________________

4 MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Full Name: _____________________________

Phone #: (_____) _____________ Date of last visit: _________

4 MEDICAL HISTORY *continued*

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: ___________________________

Are you taking any prescription/over-the-counter medications? ☐ Yes ☐ No

Please list each one: ___________________________

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #:__________

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding
Y N Anemia
Y N Artificial Bones/Joints/Valves
Y N Asthma/Arthritis
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Drug/Alcohol Abuse
Y N Emphysema
Y N Epilepsy/Seizures/Fainting
Y N Fever Blisters/Herpes
Y N Glaucoma
Y N Heart Attack/Stroke
Y N Heart Murmur
Y N Heart Surgery/Pacemaker
Y N Hemophilia
Y N Hepatitis
Y N High/Low Blood Pressure
Y N HIV+/AIDS
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic/Scarlet Fever
Y N Severe/Frequent Headaches
Y N Shingles
Y N Sickle Cell Disease/Traits
Y N Sinus Problems
Y N Tuberculosis (TB)
Y N Ulcers/Colitis
Y N Venereal Disease

Please list any serious medical condition(s) that you have ever had: ___________________________

Are you allergic to any of the following?

Y N Aspirin
Y N Any Metals/Plastics
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Other

Please list any other drugs/materials that you are allergic to: _________

____

5 DENTAL HISTORY

What are the main concerns that you would like orthodontics to accomplish?___________________________

____

Have you ever had or been evaluated for orthodontic treatment? ☐ Yes ☐ No

Have you ever had orthodontic treatment? ☐ Yes ☐ No

Age: ____ Orthodontist's Name: ___________________________

Address/City & State: ___________________________

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain or Discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your Gums ever bleed? ☐ Yes ☐ No

Have you ever had an injury to your: Mouth Teeth Chin (please circle)

Do you have any speech problems?___________________________

Do you generally breathe through your mouth? ☐ Yes ☐ No
If yes, please circle: While Awake? While Asleep?

Do you have any missing/extra permanent teeth? ☐ Yes ☐ No

Have you ever taken Phen-Fen? (Also known as Redux or Pondimin) ☐ Yes ☐ No

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

Have you ever suffered from Bulimia? ☐ Yes ☐ No

Explain: ___________________________

____

Have you ever taken a Bisphosphonate? (Also known as Fosamax, Actonel, Boniva, Skelid, Didronel, Aredia, Zometa) ☐ Yes ☐ No

Explain: ___________________________

- I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.
- Our Privacy Policy is on our website: www.drdougbrown.com
- The Patient is responsible for payment. **I hereby authorize Douglas M. Brown, DDS, MS, Inc. to obtain a copy of my credit report from a credit reporting agency for the purpose of considering payment options. Credit history is used to evaluate financing for orthodontic treatment and will not be retained, reports will be destroyed following credit evaluation.**
  NOTE: *Obtaining an Equifax credit report does not alter the responsible party's credit score in any way*

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Signature Date

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

I verbally reviewed the medical / dental information above with the parent named herein. Initials:_______ Date:________

Doctor's Comments:

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