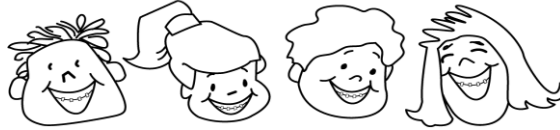


# Smiles by



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

Date \_\_\_\_\_

## Confidential Patient Information

Patient's Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Email \_\_\_\_\_

Social Security \_\_\_\_\_ General Dentist \_\_\_\_\_ City \_\_\_\_\_

Whom May We Thank for Referring You? \_\_\_\_\_

## Confidential Responsible Party Information

**Name** \_\_\_\_\_ Marital Status \_\_\_\_\_  
Last First Middle

Residence \_\_\_\_\_  Own  Rent  
Street City State Zip

Mailing Address \_\_\_\_\_ Email \_\_\_\_\_  
Street City State Zip

How long at this address \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Years Employed \_\_\_\_\_

**Name** \_\_\_\_\_ Marital Status \_\_\_\_\_  
Last First Middle

Residence \_\_\_\_\_  Own  Rent  
Street City State Zip

Mailing Address \_\_\_\_\_ Email \_\_\_\_\_  
Street City State Zip

How long at this address \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Years Employed \_\_\_\_\_

## Insurance Information

Policy Holder's Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group \_\_\_\_\_ Union Local \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Insurance Co. Phone \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_

Do you have dual coverage? No  Yes  If yes: \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Social Security \_\_\_\_\_

## Emergency Contact Information

Name \_\_\_\_\_  
Last First

Residence \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

### MEDICAL HISTORY

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

Please list other drugs/materials that you are allergic to: \_\_\_\_\_  
 \_\_\_\_\_

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

### DENTAL HISTORY

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

Date of last dental cleaning: \_\_\_\_\_  
Month Year

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 previous dental work?  Yes  No

Do you now or have you ever experienced pain or Discomfort in your jaw joint (TMJ/TMD)?  Yes  No  
 If yes, explain: \_\_\_\_\_

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

I understand that where appropriate, credit bureau reports will be obtained. \_\_\_\_\_  
Signature (Parent's signature if minor)

#### Patient Information Updates (If information has not changed, please initial below with name and date)

Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Print Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
 Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Print Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

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I verbally reviewed the medical information above with the patient or parent/guardian herein. \_\_\_\_\_ A B  
 C  
Doctor's Initials      Date