# Brooke A Henage, DMD

We would like to say thank you for selecting our dental team! So that we may better serve you, please provide or update this information for us. This practice is HIPPA compliant and all information is secured for treatment and insurance purpose only. Your thoroughness is greatly appreciated.

## Patient Information

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

Social Security #: _____ Birth Date:_____ Gender: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone : _____

Address: _____
Street Apartment # E-MAIL ADDRESS

_____
City State Zip Code

## Health Information

Date of Last Dental Visit: _____ Reason for today's visit: _____

**Have you ever had any of the following? Please check those that apply:**

**MEDICAL HISTORY**

- ☐ Allergies _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Dizziness / Fainting
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Growths / Tumors
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur / MVP
- ☐ Hepatitis / Jaundice
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Mental Health Issues
- ☐ Pacemaker
- ☐ Pain in Jaw Joints
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Ulcers
- ☐ Venereal Disease

**DRUG ALLERGIES**

- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Other_____

**WOMEN**

- ☐ Are you pregnant?

Due Date:_____

- ☐ Are you nursing?
- ☐ Are you taking birth control?

**Dental History**

- ☐ Bite/ Chew Nails
- ☐ Bite guard Therapy
- ☐ Bleeding Gums
- ☐ Bleaching Treatment
- ☐ Blisters/ Sores on Lips
- ☐ Burning sensation on tongue
- ☐ Chew on one side of mouth
- ☐ Cigarette, pipe, or cigar smoking
- ☐ Clench/ Grind Teeth
- ☐ Gums swollen or tender
- ☐ Jaw Pain or tiredness
- ☐ Loose teeth or broken fillings
- ☐ Mouth Breathing
- ☐ Mouth pain, brushing
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Sensitivity to cold, heat or sweets
- ☐ Wisdom teeth removed

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

- Do you take **antibiotics** for dental appointments? _____If so what antibiotic do you take:_____
- Are you taking **Coumadin** or other **blood thinners**? ☐ Yes ☐ No
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____

*****************PLEASE LIST ALL CURRENT MEDICATIONS** (Prescribed and over the counter)

_____
_____
_____

- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

## Responsible Party Information

Name:_____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____

Social Security #: _____ Birth Date:_____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone or Pager: _____

Address:_____
Street Apartment #

_____
City State Zip Code **E-MAIL ADDRESS**

Responsible Party
Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

## Insurance Information

**Primary**

Name of Insured: _____Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Other _____

Insurance Plan Name and Address: _____

_____

**Secondary**

Name of Insured: _____Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Other _____

Insurance Plan Name and Address: _____

_____

## Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice_____

## Consent for Services

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. If there is any change in my medical status, I will inform the dentist. I understand that this information will be used by my dentist to help determine appropriate and healthful dental treatment. I grant my permission to you or your assignee to telephone me at home or at my work to discuss matters related to this form. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to me during the period of such care to third party payers and/ or other health practitioners.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, or guardian