

Tim J. Brooks DDS
"The Art & Science of a Healthy Smile"
 12448 Saint Andrews Drive - Oklahoma City, OK 73120

Patient Health History & Information

Name _____ Preferred name _____ Date _____
First Middle Last
 Address _____ City _____ State _____ Zip Code _____
 Home Phone _____ Work Phone _____ ext. _____ Cell Phone _____
 Birth date _____ Social Security _____ DL# _____ State _____ Exp. _____
 Email Address _____ Circle: Child Single Married Divorced Widowed Gender: M / F
 Employer _____ Employer Address _____ Position _____
City State
 Referred by? _____ Emerg. contact _____ Relationship _____ Ph. _____
 Spouse's Name _____ Birthdate _____ Social Security _____
 Spouse's Employer _____ Spouse's Work Phone _____ Spouse's Cell _____
 Who is the person responsible for this account? _____ Relationship to patient _____

DENTAL INSURANCE INFO

Name of Insured _____ Birth date _____ Social Security _____
 Employer _____ Insurance Co. _____ Phone _____

MEDICAL HISTORY

Physician's Name and Address _____ Phone _____

Have you had any recent serious illnesses or operations? _____

Have you ever had a blood transfusion? Yes or No If yes, please give approximate dates _____

Have you ever been told you need to pre-medicate prior to dental appointments due to a medical condition? Yes or No

Women: Are you pregnant? Yes or No Due Date: _____ Are you nursing? Yes or No
 Are you taking Birth Control Pills? Yes or No Are you planning on becoming pregnant? Yes or No

Please check if you have or have had any of the following:

- | | | | |
|-------------------------------------------------|--------------------------------------------------|------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Amoxicillin Allergy | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Sulfa Allergy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Erythromycin Allergy | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Swelling of Feet/Ankles |
| <input type="checkbox"/> Anesthetic Allergy | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Mouth Sores | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Hearing Disorder | <input type="checkbox"/> Psychiatric Problems | |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Respiratory Disease | |
| <input type="checkbox"/> Cancer _____ | (please circle A - B - C) | <input type="checkbox"/> Rheumatic Fever | Other Conditions: |
| <input type="checkbox"/> Chemotherapy/Radiation | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever | _____ |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> HIV Positive/ AIDS | <input type="checkbox"/> STD _____ | _____ |
| <input type="checkbox"/> Codeine Allergy | <input type="checkbox"/> Joint/Hip Replacement | <input type="checkbox"/> Shortness of Breath | _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney/Liver Disease | <input type="checkbox"/> Sleep Apnea | _____ |

Please list all prescribed and over the counter medications you are currently taking with the correlating diagnosis:

Herbal Supplements: _____

Medication Allergies: _____

DENTAL HISTORY

Previous Dentist Name and Address _____

When was your last visit to the dentist? _____ When was your last full mouth x-rays taken? _____

How would you rate your smile? Needs Improvement or Excellent

If you had a magic wand what would you change about your smile?

What, if any, would keep you from having dental treatment completed: Fear / Finances / Pain / Time
Circle all that apply

Have you ever had any serious trouble associated with previous dentistry? _____

Have you ever been diagnosed or treated for periodontal disease? (gum disease, pyorrhea, trench mouth) _____

Does dental treatment make you nervous? No _____ Slightly _____ Moderately _____ Extremely _____

How often do you brush your teeth? _____ Floss? _____ Toothbrush is: Soft / Medium / Hard / Electric

Please check if you have or have had any of the following:

- | | | |
|--------------------------------------------------------|----------------------------------------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> Bleeding/Sore Gums | <input type="checkbox"/> Clenching/Grinding Teeth | <input type="checkbox"/> Sensitivity to Heat |
| <input type="checkbox"/> Unpleasant Taste/Bad Breath | <input type="checkbox"/> Loose Teeth or Broken Fillings | <input type="checkbox"/> Sensitivity to Sweets |
| <input type="checkbox"/> Clicking or Popping Jaw | <input type="checkbox"/> Sensitivity when Biting | <input type="checkbox"/> Sensitivity to Cold |
| <input type="checkbox"/> Food Collection between Teeth | <input type="checkbox"/> Sores or Growths in your Mouth | <input type="checkbox"/> Orthodontics |
| <input type="checkbox"/> Biting Cheeks/Lips | <input type="checkbox"/> Frequent Blisters on lips/mouth | <input type="checkbox"/> Difficulty opening or closing jaw |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Mouth Piercing | <input type="checkbox"/> Pain in your jaw joint or your face/ear |
| <input type="checkbox"/> Stained Teeth | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Chipped or Broken Teeth |
| <input type="checkbox"/> Missing Teeth | <input type="checkbox"/> Achy Pain in Teeth | <input type="checkbox"/> Throbbing Pain |
| <input type="checkbox"/> Partial Dentures | <input type="checkbox"/> Complete Dentures | <input type="checkbox"/> Dental Implants |

To better serve your individual patient needs, we would like to have your permission to provide the following services. We thank you for your time.

- | | |
|-----------------------------------------------------------------------------|-----------|
| ➤ Mail appointment reminder postcards to your home address? | Yes or No |
| ➤ Contact previous dentist regarding dental history | Yes or No |
| ➤ Leave messages at your home phone number? | Yes or No |
| ➤ Mail billing statements to your home address? | Yes or No |
| ➤ Mail newsletters regarding information changes? | Yes or No |
| ➤ Permission to discuss your children with both of their parents? | Yes or No |
| ➤ Use records/photos of your dental case for presentations or publications? | Yes or No |

AUTHORIZATION AND RELEASE

In accordance with the Privacy Rules of HIPAA and with my understanding of the Patient Notice that I have read, I am hereby giving my full consent to Dr. Tim J. Brooks to maintain my medical records, transmit, forward and or release information about me, my health information and/or my Personal Health Information to any applicable person(s) or agencies, provided it is in my best interest and/or for the advancement or continuance of any health care services which I am being treated. I have read and answered the above questions to the best of my knowledge. I understand that I am ultimately financially responsible for all charges. By signing below I acknowledge my understanding of all terms and conditions.

Patient name printed Date _____

Patient signature Date _____

~ Payment is due in full at time of treatment unless prior arrangements have been approved. ~