Welcome!

Lindsay Freed Brown, DMD
Randall N. Freed, DMD, FAGD

PATIENT INFORMATION

Name _____
Last Name *First Name* *Middle Initial*

Date of Birth _____ SSN _____ Sex ☐ M ☐ F Referred By _____

Address _____ City _____ State _____ Zip _____

Cell Phone_____ Home Phone_____ Email_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Business Address _____ Business Phone _____ Occupation _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name *First Name* *Middle Initial*

Relation to Patient _____ Birthdate _____ SSN _____

Address (if different from patient)_____City _____ State _____ Zip _____

Cell Phone_____ Home Phone_____ Email_____

Employer of Person Responsible _____ Occupation _____

Business Address _____ Business Phone_____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No Subscriber Name _____

Relation to Patient _____ Birthdate _____ SSN _____

Address (if different from patient)_____City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____ Email _____

Employer of Subscriber _____ Business Phone _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

SEE PAGE 2

DENTAL HISTORY

What would you like us to do today? _____ Are you in dental discomfort today? ☐ Y ☐ N
Former Dentist _____ Address _____
Former Dentist Phone Number _____ Date of last dental care _____ Date of last x-rays _____
Check (✓) yes or no if you have had problems with any of the following:

☐ Y ☐ N	Bad breath	☐ Y ☐ N	Food collection between teeth	☐ Y ☐ N	Sensitivity to hot
☐ Y ☐ N	Bleeding gums	☐ Y ☐ N	Grinding or clenching	☐ Y ☐ N	Sensitivity to sweets
☐ Y ☐ N	Clicking or popping gums	☐ Y ☐ N	Loose teeth or broken fillings	☐ Y ☐ N	Sensitivity when biting
☐ Y ☐ N	Periodontal treatment	☐ Y ☐ N	Sensitivity to cold	☐ Y ☐ N	Sores or growths in mouth

How often do you brush? _____ Floss? _____
How do you feel about the appearance of your teeth? _____
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Y ☐ N
Other information about your dental health or previous treatment _____

MEDICAL HISTORY

Physician's Name _____ Phone_____ Date of last visit _____
Have you had any serious illness or operations? ☐ Y ☐ N If yes, describe _____
Are you currently under physician care? ☐ Y ☐ N If yes, describe _____
Have you ever had a blood transfusion? ☐ Y ☐ N If yes, give approximate dates _____
Women: Are you Pregnant? ☐ Y ☐ N Nursing? ☐ Y ☐ N Taking birth control pills? ☐ Y ☐ N
Drug allergies? If yes, list all: _____
Have you ever taken Fen-Phen/Redux? ☐ Y ☐ N

Check (✓) yes or no if you have had any of the following:

☐ Y ☐ N	AIDS/HIV Positive	☐ Y ☐ N	Circulatory problems	☐ Y ☐ N	Jaw pain	☐ Y ☐ N	Shingles
☐ Y ☐ N	Allergies (Food)	☐ Y ☐ N	Cortisone treatments	☐ Y ☐ N	Kidney disease or malfunction	☐ Y ☐ N	Shortness of breath
☐ Y ☐ N	Allergies (Material – i.e. latex, wool, metal, chemicals)	☐ Y ☐ N	Cough, persistent			☐ Y ☐ N	Skin rash
		☐ Y ☐ N	Cough up blood	☐ Y ☐ N	Liver disease	☐ Y ☐ N	Spina bifida
☐ Y ☐ N	Anaphylaxis	☐ Y ☐ N	Diabetes (Type I or II)	☐ Y ☐ N	Mitral valve prolapse	☐ Y ☐ N	Stroke
☐ Y ☐ N	Anemia	☐ Y ☐ N	Epilepsy	☐ Y ☐ N	Nervous problems	☐ Y ☐ N	Surgical implant
☐ Y ☐ N	Arthritis, Rheumatism	☐ Y ☐ N	Fainting	☐ Y ☐ N	Osteoporosis	☐ Y ☐ N	Swelling of feet/ankles
☐ Y ☐ N	Artificial heart valves	☐ Y ☐ N	Glaucoma	☐ Y ☐ N	Pacemaker/ heart surgery	☐ Y ☐ N	Thyroid disease or malfunction
☐ Y ☐ N	Artificial joints	☐ Y ☐ N	Headaches	☐ Y ☐ N	Psychiatric care	☐ Y ☐ N	Tobacco habit
☐ Y ☐ N	Asthma	☐ Y ☐ N	Heart murmur	☐ Y ☐ N	Rapid weight loss/gain	☐ Y ☐ N	Tonsillitis
☐ Y ☐ N	Back problems	☐ Y ☐ N	Hemophilia/ Abnormal bleeding	☐ Y ☐ N	Radiation treatment	☐ Y ☐ N	Tuberculosis
☐ Y ☐ N	Blood disease			☐ Y ☐ N	Respiratory disease	☐ Y ☐ N	Ulcer/Colitis
☐ Y ☐ N	Cancer	☐ Y ☐ N	Herpes	☐ Y ☐ N	Rheumatic/Scarlet fever	☐ Y ☐ N	Venereal disease
☐ Y ☐ N	Chemical dependency	☐ Y ☐ N	Hepatitis				
☐ Y ☐ N	Chemotherapy	☐ Y ☐ N	High blood pressure				

Are you currently taking any medications? If yes, list all: _____

_____

_____

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ **Date** _____

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