

BOWMAN R. BROWNE, D.D.S.

PLEASE PRINT NAME: _____ DATE: _____
ADDRESS: _____ DATE OF BIRTH: _____
MARITAL STATUS: S M W D
BUSINESS PHONE: _____
HOME PHONE: _____ CELL PHONE: _____
SOCIAL SECURITY NO: _____ OCCUPATION: _____
EMPLOYER: _____ REFERRED BY: _____
IN CASE OF EMERGENCY PLEASE CONTACT: _____ PHONE: _____
PERSON RESPONSIBLE FOR ACCOUNT: _____
DENTAL INSURANCE PLAN: _____ POLICY NUMBER: _____
IDENTIFICATION NUMBER: _____ INSURERS PHONE NO: _____

MEDICAL HISTORY

In order to provide you with the best dental care, the following information is necessary.

1. Are you having pain or discomfort at this time? YES NO
2. When was your last visit to the dentist? _____
3. Have you been in the hospital during the last five years? YES NO
If so, what for? _____
4. Your physician's name _____ Phone _____
5. Do you take any prescribed medicines or drugs? YES NO
6. Are you allergic to any drugs, medication or specific foods? YES NO
If so, what? _____
7. Have you had abnormal or severe bleeding after tooth extraction, surgery or injury? YES NO
8. Do you have shortness of breath or chest pains? YES NO
9. WOMEN: Are you pregnant or suspect that you are? YES NO
10. Do you have diabetes? YES NO
11. Do you have an abnormal heart condition? YES NO
12. Have you had rheumatic fever? YES NO
13. Have you ever had a heart murmur? YES NO
14. Have you ever been told by a doctor that you needed pre-medication before a dental appointment? YES NO
15. Do you have high blood pressure? YES NO
16. Do you have an abnormal kidney condition? YES NO
17. Do you have an abnormal lung condition? YES NO
18. Have you ever had a stroke? YES NO
19. Do you have hepatitis? YES NO
20. Do you have HIV? YES NO
21. Do you have any artificial joints or valves? YES NO
22. Have you ever had an organ transplant? YES NO
23. Have you ever taken phen phen or redox? YES NO

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORRECT. IF I HAVE ANY CHANGE IN MY HEALTH OR IN MY MEDICATION, I WILL INFORM THE STAFF. I ALSO AGREE TO ANY BLOOD TEST REQUIRED IF THE STAFF OBTAINS AN INJURY FROM A CONTAMINATED NEEDLE OR INSTRUMENT DURING MY TREATMENT.

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

Signature _____