**Dr. Paul C. Brooks III, DMD**
**3600 Lexington Road**
**Louisville,**
**Kentucky 40207**

**Confidential Patient Information-I**
*(Please Print Legibly)*

**Date:**

## Personal Information:

Name:
Address:
City:
Telephone: SS#:
E-mail: BirthDate: Sex:
Marital Status: Spouse Name:
Occupation: Referred by:

## Person Responsible for Account

Name: Relationship SS#
Address:
City: State: Zip:
Telephone: (H) (W)

## Dental Insurance Information

Primary Insurance Company:
Insurance Co. Address
Employee with ins Relationship SS#
Employer: Policy
Secondary InsuranceCo: Insurance Co
Employer with Insurance: Relationship SS#
Employer: Policy

I understand that payment is my obligation regardless of insurance or any other third party involvement.

Signature: Date

## Payment Methods

For your convenience, we offer the following methods of payment
Please check the option you prefer

- ◯ Cash
- ◯ Check
- ◯ Credit card

**Confidential Patient Information-II**
**(Please Print Legibly)**

## Patient Information(||)

**Patient Name:**

**Initial Date:**

**Update:** **By:** **Update:** **By:**

## Health Information

**Personal Physician Name:**

**Have you been hospitalized within the past 2 years:** ☐ Yes ☐ No

**if yes, for what?:**

**Are you currently being treated by a physician:** ☐ Yes ☐ No

**if yes, for what?:**

**Are you currently taking medications or drugs:** ☐ Yes ☐ No

**if yes, for what?:**

**Are you allergic to any medications?:** ☐ Yes ☐ No

**if yes, for what?:**

**Are you allergic to latex:** ☐ Yes ☐ No

**Are you allergic to any metals? What?:** ☐ Yes ☐ No

**Have, you ever had a skin rash or other reaction to metal jewelry? To what?** ☐ Yes ☐ No

**Do you bleed excessively upon injury** ☐ Yes ☐ No

**Are you pregnant**

## Circle Of The Follwing Conditions Which You Have Had

| | | |
|---|---|---|
| **A. AIDS** | **F. Epilepsy** | **K. High Blood Pressure** |
| **B. Arthritis** | **G. Glaucoma** | **L. Jaundice** |
| **C. Asthma** | **H. Heart Murmur** | **M. Kidney Problems** |
| **D. Cancer** | **I. Heart Problem** | **N. Low Blood Pressure** |
| **E. Diabetes** | **J. Hepatitis** | **0. Nervous Breakdown or Psychiatric Therapy** |
| **P. Rheumatic Fever** | **Q. Stroke** | **R. Sexually Transmitted diseases** |
| **S. Tuberculosis** | **T. Other Diseases** | |

**if you circled either I or T describe**

# Dental Information - III

## Dental History

Reason for today's visit

_____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

| | |
|---|---|
| Bad breath | ☐ Yes ☐ No |
| Bleeding gums | ☐ Yes ☐ No |
| Blisters on lips or mouth | ☐ Yes ☐ No |
| Burning sensation on tongue | ☐ Yes ☐ No |
| Chew on one side of mouth | ☐ Yes ☐ No |
| Cigarette, pipe, or cigar smoking | ☐ Yes ☐ No |
| Clicking on popping jaw | ☐ Yes ☐ No |
| Dry mouth | ☐ Yes ☐ No |
| Are you taking or have you ever taken Bisphosphonates? | ☐ Yes ☐ No |
| Foreign objects | ☐ Yes ☐ No |
| Grinding teeth | ☐ Yes ☐ No |
| Gums swollen or tender | ☐ Yes ☐ No |
| Jaw pain or tiredness | ☐ Yes ☐ No |
| Lip or cheek biting | ☐ Yes ☐ No |
| Loose teeth or broken fillings | ☐ Yes ☐ No |
| Mouth breathing | ☐ Yes ☐ No |
| Mouth pain, brushing | ☐ Yes ☐ No |
| Orthodontic treatment | ☐ Yes ☐ No |
| Pain around ear | ☐ Yes ☐ No |
| Periodontal treatment | ☐ Yes ☐ No |
| Sensitivity to cold | ☐ Yes ☐ No |
| Sensitivity to heat | ☐ Yes ☐ No |
| Sensitivity to sweets | ☐ Yes ☐ No |
| Sensitivity when biting | ☐ Yes ☐ No |
| Sores or growths in your mouth | ☐ Yes ☐ No |
| How often do you floss? | ☐ Yes ☐ No |
| How often do you brush? | ☐ Yes ☐ No |

Do you like your smile? _____