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

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
Do you floss?	☐ Yes ☐ No
If yes, how often?	___________
How often do you brush?	___________

Do you like your smile? ________________