Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	☐	☐
3. Are you taking any medication (s) including non-prescription medicine? If yes, Please List any you are taking. _____ _____	☐	☐
4. Do you use tobacco?	☐	☐
5. Do you use controlled substances?	☐	☐

Has Your Physician told you to take Antibiotics before dental care? ☐ Yes ☐ No

	Yes	No
7. Are you taking any Herbal Supplements_____	☐	☐
8. Are you allergic to or have you had any reactions to the following?	Yes	No
Codeine	☐	☐
Local Anesthetics	☐	☐
Penicillin (or other Antibiotics)	☐	☐
Sulfa Drugs	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____	☐	☐
9. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you taking oral contraceptives?	☐	☐
10. Are you taking medication for osteoporosis?	☐	☐
11. Are you taking coumadin?	☐	☐

6. Do you or have you experienced any of the following?

	Yes	No		Yes	No		Yes	No
Heart Disease/Attack	☐	☐	Allergies	☐	☐	Prolonged Bleeding	☐	☐
High Blood Pressure	☐	☐	Diabetes	☐	☐	Cold Sores/Fever Blisters	☐	☐
Rheumatic Fever	☐	☐	Kidney Diseases	☐	☐	Cancer	☐	☐
Heart Murmur	☐	☐	AIDS Infection	☐	☐	Glaucoma	☐	☐
Heart Surgery	☐	☐	HIV Infection	☐	☐	Hepatitis A,B,C	☐	☐
Mitral Valve Prolapse	☐	☐	Sexually Transmitted Disease	☐	☐	Jaundice	☐	☐
Heart Valve Replacement	☐	☐	Emphysema	☐	☐	Arthritis	☐	☐
Stroke	☐	☐	Tuberculosis (TB)	☐	☐	Joint Replacement	☐	☐
Fainting	☐	☐	Radiation/Cobalt Treatment	☐	☐	Implant	☐	☐
Seizures/Epilepsy	☐	☐	Thyroid Problem	☐	☐	Bisphosphonates	☐	☐
Asthma	☐	☐				Other	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

1. Date of Last full mouth X-ray or Panoramic X-Ray_____

	Yes	No
2. Do your gums bleed while brushing or flossing?	☐	☐
3. Are your teeth sensitive?	☐	☐
4. When was the last time you had your teeth professionally cleaned? _____		
5. Why are you changing dentists? _____		
6. Do you feel pain with any of your teeth?	☐	☐
7. Do you have any sores or lumps in or near your mouth?	☐	☐
8. Have you had any head, neck or jaw injuries?	☐	☐
9. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
10. Do you clench or grind your teeth?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials? If yes, date of placement	☐	☐
15. Are you interested in whitening your teeth?	☐	☐
16. Would you like to discuss how we could improve your smile?	☐	☐
17. Would you like to discuss what cosmetic dentistry could do for you?	☐	☐

1. I affirm that the information given today is correct. I understand that it is my responsibility to inform this office of any changes in my medical history. _____
2. All accounts are due and payable as treatment progresses, regardless of insurance coverage. The portion of our fee which is not covered by your insurance company is due at the time of each visit.
3. Please be certain to bring at least one insurance form for each appt. We will be happy to submit your forms to your insurance company for payment; however, the responsibility for payment ultimately lies with you the patient. Within 60 days of filing, payment is expected by either you or your insurance company.
4. After 90 days, a billing charge of 1.5% of the unpaid balance will be added to the account monthly.

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO DENTAL CLAIMS. _____

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DENTIST FOR INSURANCE BENEFITS OTHERWISE PAYABLE TO ME: _____

Drs. Pafford and Browning, D.M.D., P.C.

Welcome

Paul E. Pafford, D.M.D.
Neil D. Browning, D.M.D.

Soc. Sec. # _____

Date _____

Email _____

Cell Phone _____

Patient Information (CONFIDENTIAL)

Name _____ ☐ Male ☐ Female Birthdate _____ Home Phone _____

Address _____ City _____ State ____ Zip _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School / College _____ City _____ State ☐ Full Time ☐ Part Time

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State ____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Spouse Birthdate _____ SS# _____

Whom May We Thank for Referring You? _____

Nearest Relative not Living with You _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work phone _____ SSN# _____

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State ____ Zip _____

Insurance Company _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State ____ Zip _____

How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐ Yes ☐ No *IF YES, COMPLETE THE FOLLOWING:*

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State ____ Zip _____

Insurance Company _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State ____ Zip _____

How Much is your deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Over Please