Welcome to the office of Dr. Robert S. Brooks & Dr. B. Wells Maddox III

PATIENT INFORMATION

Patient Name: ______________________ **Date:** __________
FIRST MIDDLE LAST

Social Security #: __________ **Birth Date:** __________ **Age:** _____ ☐ **Male** ☐ **Female**

Address: ______________________ **Phone:**
STREET APT#

____
CITY STATE ZIP CODE

☐ **Married** ☐ **Female**

☐ **Child** ☐ **Other** __________

EMPLOYMENT OR COLLEGE ATTENDANCE INFORMATION

Occupation: ______________________

Employer/College: ______________________

Work/College Address: ______________________
STREET APT/SUITE#

____
CITY STATE ZIP CODE

Phone: ______________ **ext:** _______

HOW MAY WE CONTACT YOU?

Home Phone: ______________

Work Phone: ______________ **ext.**_____

Pager: ______________

Mobile: ______________

E-mail: ______________

SPOUSE OR RESPONSIBLE PARTY INFORMATION
(circle one)

Name: ______________ **Social Security #** __________ **Birth Date:** ________ ☐ **Male** ☐ **Female**

Address: ______________________ **Home Phone:** ______________

Employer Name/Address: ______________________ **Work Phone:** ______________

INSURANCE INFORMATION

PRIMARY

Name of Insured: ______________________ **Is insured a patient?** ☐ **Yes** ☐ **No**

Insured's Birth Date: __________ **ID #:** __________ **Group#:** __________

Insured Address: ______________________
STREET CITY STATE ZIP CODE

Insured Employer Name: ______________________

Address: ______________________
STREET CITY STATE ZIP CODE

Patient's relationship to insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other** __________

Insurance Plan Name and Address: ______________________

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SECONDARY

Name of Insured: ______________________ **Is insured a patient?** ☐ **Yes** ☐ **No**

Insured's Birth Date: __________ **ID #:** __________ **Group#:** __________

Insured Address: ______________________
STREET CITY STATE ZIP CODE

Insured Employer Name: ______________________

Address: ______________________
STREET CITY STATE ZIP CODE

Patient's relationship to insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other** __________

Insurance Plan Name and Address: ______________________

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(Please continue on back side)

Referral Information

Whom may we thank for referring you to our practice? ❑ **Another patient, friend** ❑ **Another patient, relative**

❑ **Dental/Doctor Office** ❑ **Yellow Pages** ❑ **School** ❑ **Work** ❑ **Other** ________________________

Name of person or office referring you to our practice: ____

Health Information

Date of Last Dental Visit: ___________________________ **Date & Type of last dental x-rays taken:** ___________________________

Are you having pain or discomfort at this time? ❑ Yes ❑ No Reason for this visit: ________________________________

- Have you ever had any complications following dental treatment? ❑ Yes ❑ No
  If yes, please explain: ________________________________
- Have you been a patient in the hospital during the past two years? ❑ Yes ❑ No
  If yes, please explain: ________________________________
- Are you under the care of a medical doctor now, or have you been in the past two years? ❑ Yes ❑ No
  If yes, please explain: ________________________________
- Name of Physician: ________________________________ Phone Number: ________________________________
- Have you taken any medication or drugs during the past two years? ❑ Yes ❑ No
  If yes, please list: ________________________________
- Are you currently taking any medication, drugs or pills? ❑ Yes ❑ No
  If yes, please list: ________________________________
- Please list any medications you are allergic to, or have reacted badly to: ________________________________
- Please indicate which of the following you have had, or have at present:

❑ A.I.D.S.	❑ Congenital Heart Disease	❑ Heart Surgery	❑ Radiation Therapy
❑ Allergies/Hives	❑ Cortisone Medication	❑ Hemophilia	❑ Respiratory Problems
❑ Anemia	❑ Cosmetic Surgery	❑ Hepatitis A Infection	❑ Rheumatic Fever
❑ Angina Pectoris	❑ Diabetes	❑ Hepatitis B (serum)	❑ Rheumatism
❑ Arteriosclerosis	❑ Drug Addiction	❑ High Blood Pressure	❑ Sickle Cell Disease
❑ Arthritis	❑ Epilepsy or Seizures	❑ H.I.V. Positive	❑ Sinus Trouble
❑ Artificial Heart Valve/Joints	❑ Excessive Bleeding	❑ Jaundice	❑ Stroke
❑ Asthma	❑ Fainting or Dizzy Spells	❑ Kidney Trouble	❑ Thyroid Problems
❑ Blood Transfusion	❑ Glaucoma	❑ Liver Disease	❑ Tuberculosis
❑ Bruise Easily	❑ Hay Fever	❑ Mental Disorders	❑ Ulcers
❑ Cancer/Tumors	❑ Heart Disease/Attack	❑ Mitral Valve Prolapse	❑ Venereal Disease
❑ Chemotherapy	❑ Heart Failure	❑ Nervous Disorders	
❑ Cold Sores/Fever Blisters	❑ Heart Murmur	❑ Pacemaker	❑ None of the Above

- When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ❑ Yes ❑ No Do your ankles swell during the day? ❑ Yes ❑ No
- Do you use more than two pillows to sleep? ❑ Yes ❑ No Do you ever wake up from sleep and feel short of breath? ❑ Yes ❑ No
- Have you lost or gained more than 10 pounds in the last year? ❑ Yes ❑ No Are you on a special diet? ❑ Yes ❑ No
- Do you have, or have you had, any disease, condition, or problems not listed above? ❑ Yes ❑ No
  If yes, please explain: ________________________________

For Women Only

Are you pregnant? ❑ Yes ❑ No If so, what is your due date?: ____________________

Are you nursing? ❑ Yes ❑ No Are you taking birth control pills? ❑ Yes ❑ No

To help us enhance your dental treatment, please check all of the following that apply to you:

❑ Fear of Dentist	❑ Lump or Swelling in Mouth	❑ Poorly Functioning Teeth	❑ Complications with Extractions
❑ Pain in Jaw, Mouth, Face	❑ Discolored Teeth	❑ Dry Mouth	❑ Clenching or Grinding of Teeth
❑ Bleeding Gums	❑ Food Wedging Between Teeth	❑ Crooked Teeth	❑ Teeth Sensitive to Heat
❑ Jaw Sounds or Pain	❑ Inability to Floss Between Teeth	❑ Pain when Opening	❑ Teeth Sensitive to Cold
❑ Poorly Fitting Dentures/Appliances		❑ Pain/Discomfort w/Dentures/Appliance	