Graig D. Brown
PERIODONTICS & IMPLANTS DDS, MS

Welcome to Dr. Brown's Office

3148 North Swan Road • Tucson, AZ 85712
(520) 790–2151 • www.perioaz.com

PATIENT INFORMATION...

Date ____________

❏ Mr. ❏ Mrs. ❏ Ms. ❏ Dr. First Name ____________ M.I. ____ Last Name ____________ Nickname ____________

Sex: ❏ Male ❏ Female Birth Date ____________ Age ____ Soc. Sec. # ____________ E-mail ____________

Street ____________ Apt. ____ City ____________ State ____ Zip ____________

Home Tel.(____) ____________ Cell.(____) ____________ Have you ever been a patient of our practice? ❏ Yes ❏ No

Referred By ____________ Has a family member ever been a patient of our practice? ❏ Yes ❏ No

Dentist ____________ Medical Doctor ____________

Employer ____________ Bus. Tel.(____) ____________

In case of emergency, please contact ____________ Tel. (____) ____________ Relation ____________

INSURANCE HOLDER FOR YOUR ACCOUNT...

❏ Self (If self, skip this section) ❏ Spouse ❏ Father ❏ Mother ❏ Other ____________

Name ____________ S.S.# ____________ Birth Date ____________ Age ____ Tel.(____) ____________

Street ____________ Apt. ____ City ____________ State ____ Zip ____________

Driver's Lic.# ____________ Employer ____________ Bus. Tel.(____) ____________

PRIMARY INSURANCE COMPANY...

Employer ____________

Bus. Address ____________

Bus. Tel.(____) ____________ **Ins. Co. Name** ____________ I.D. # ____________

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

Ins. Co. Tel.(____) ____________ **Group #** ____________ **Group Name** ____________

Insurance Holder ____________ Relation ____________ Sex: ❏ M ❏ F Birth Date ____________

Social Security # ____________ Street ____________

City ____________ State ____________ Zip ____________ Tel.(____) ____________

DENTAL INFORMATION...

Reason for today's visit ____________

Are you in pain? ❏ Yes ❏ No, For How Long? ____________

Please indicate any of the following problems by checking off the corresponding box:

❏ Discomfort, clicking, or popping in jaw
❏ Red, swollen, or bleeding gums
❏ A removable dental appliance
❏ Blisters / sores in or around the mouth
❏ Prolonged bleeding from an injury / extraction
❏ Recent infections or sore throat
❏ Lost / broken filling(s)
❏ Teeth grinding / clenching
❏ Ringing in ears
❏ Broken / chipped tooth
❏ Gum disease
❏ Other ____________
❏ Stained teeth
❏ Locking jaw
❏ Bad breath
❏ Burning tongue / lips
❏ Toothache
❏ Difficulty closing jaw
❏ Difficulty opening jaw
❏ Loose / shifting teeth
❏ Food caught between teeth
❏ Swelling / lumps in mouth

❏ My teeth are sensitive to: ❏ Hot ❏ Cold ❏ Sweets ❏ Biting

Last dental exam ____________ Last dental x–rays ____________ Times a day you brush? ____ Times a week you floss? ____

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

What type of toothbrush bristles do you use? ❏ Soft ❏ Medium ❏ Hard

MEDICAL HISTORY...

Are you in good health? ❑ Yes ❑ No Height ____________ Weight __________ Are you under the care of a physician? ❑ Yes ❑ No

Have you had any illness, operation, or been hospitalized in the past five years? ❑ Yes ❑ No

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y N
- ❑ ❑ Rheumatic fever
- ❑ ❑ Mitral valve prolapse
- ❑ ❑ Heart murmur
- ❑ ❑ High blood pressure
- ❑ ❑ Low blood pressure
- ❑ ❑ Chest pain / Angina
- ❑ ❑ Heart attack(s)
- ❑ ❑ Irregular heart beat
- ❑ ❑ Cardiac pacemaker
- ❑ ❑ Heart surgery
- ❑ ❑ Pneumonia / Bronchitis / Chronic cough
- ❑ ❑ Chronic fatigue / Night sweat
- ❑ ❑ Trouble climbing 1-2 flights of stairs
- ❑ ❑ Mental health problems
- ❑ ❑ Damaged heart valves
- ❑ ❑ Asthma

Y N
- ❑ ❑ Are you immunosuppressed? *(possibly from transplant surg.)*
- ❑ ❑ Hay fever / Sinus problems
- ❑ ❑ Snoring / Sleep apnea
- ❑ ❑ Respiratory problems
- ❑ ❑ Tuberculosis
- ❑ ❑ Emphysema
- ❑ ❑ Do you smoke
- ❑ ❑ Do you use chewing tobacco
- ❑ ❑ Blood transfusion
- ❑ ❑ Blood disorder
- ❑ ❑ Bruise easily
- ❑ ❑ A history of drug abuse
- ❑ ❑ Eye disease / Glaucoma
- ❑ ❑ Abnormal bleeding
- ❑ ❑ Bleeding tendency

Y N
- ❑ ❑ Problems w/ immune system? *(possibly from med. / surg.)*
- ❑ ❑ Jaundice / Liver disease
- ❑ ❑ Hepatitis
- ❑ ❑ Infectious mononucleosis
- ❑ ❑ Gallbladder trouble
- ❑ ❑ Fainting spells
- ❑ ❑ Convulsions / Epilepsy
- ❑ ❑ Stroke
- ❑ ❑ Thyroid trouble
- ❑ ❑ Diabetes
- ❑ ❑ A history of alcohol abuse
- ❑ ❑ Sexually transmitted diseases
- ❑ ❑ Swollen ankles
- ❑ ❑ Low blood sugar
- ❑ ❑ Kidney trouble

Y N
- ❑ ❑ Are you on dialysis
- ❑ ❑ Arthritis / Joint disease
- ❑ ❑ Osteoporosis / Osteopenia
- ❑ ❑ Osteonecrosis
- ❑ ❑ Stomach ulcers
- ❑ ❑ Contagious diseases
- ❑ ❑ Delay in healing
- ❑ ❑ Anemia
- ❑ ❑ Tumor or growth
- ❑ ❑ Cancer / Radiation / Chemotherapy
- ❑ ❑ Are you on a diet
- ❑ ❑ Contact lenses
- ❑ ❑ Immune system problems

MEDICATION & ALLERGIES...

Are you now taking, or have you ever taken:

Y N
- ❑ ❑ Nerve pills
- ❑ ❑ Diet pills
- ❑ ❑ Blood thinners (Coumadin, Aspirin, Advil)
- ❑ ❑ Any bone density medication or Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)

Y N
- ❑ ❑ Pain killers (including aspirin)
- ❑ ❑ Tranquilizers

Y N
- ❑ ❑ Muscle relaxers
- ❑ ❑ Insulin

Y N
- ❑ ❑ Stimulants
- ❑ ❑ Antidepressants

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

Are you allergic to, or had a reaction to:

Y N
- ❑ ❑ Penicillin / Amoxicillin
- ❑ ❑ Codeine or other narcotics

Y N
- ❑ ❑ Local anesthetic (numbing med)
- ❑ ❑ Latex

Y N
- ❑ ❑ Valium or other tranquilizers
- ❑ ❑ Sulfites

Y N
- ❑ ❑ Aspirin
- ❑ ❑ I have no known allergies.

Please list any other medication or antibiotic you are allergic to:

____

____

Please list any allergies other than drug allergies:

____

____

1-4 below for women only: *(Women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.)*

1) Is there a possibility of pregnancy? ❑ Yes ❑ No

2) Expected delivery date: ______________

3) Are you nursing? ❑ Yes ❑ No

4) Are you taking birth control pills: ❑ Yes ❑ No

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X ______________________ **X** ______________________ **X** ____________

Signature of patient *(Parent or Guardian if Minor)* **Reviewed by** **Date**

AUTHORIZATION & CONSENT

I authorize the office of Dr. Graig Brown to release any information including the diagnosis and records of treatment of examination for myself and my dependent(s) to third party insurance carriers, payors, and/or health-care practitioners.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any). This dental office cannot render services on the assumption that our fees will be paid by an insurance company.

As a courtesy, we will electronically file your insurance claims and have your insurance company reimburse you directly.

I have read the above conditions of treatment and payment and agree to their content

X ______________________________ **X** ____________

Signature of patient *(Parent or Guardian if Minor)* **Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X ______________________________ **X** ____________

Signature of patient: *(Parent or Guardian if Minor)* **Date**

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X ______________________________ **X** ____________

Signature of patient *(Parent or Guardian if minor)* **Date**

021811 • Copyright © 2011 Protective Business and Health Systems, Inc. • To re-order call 800.782.4952