KAREN L. BRUNE, D.D.S., P.A.
1300 POST OAK BLVD., SUITE 1620 / 713.622.6112
FAX 713.622.2351 / www.houstonuptowndentists.com / e-mail: info@houstonuptowndentists.com

WELCOME TO OUR OFFICE! Please complete the following so that we may provide you with the safest and most comfortable, comprehensive, and efficient dental care possible.

PATIENT INFORMATION

______________ ______________ ______________ ______________
Dr./Mr./Mrs./Ms./Miss/Other Last Name First Name Middle Name
Today's Date: ______________
Residence Address: ______________ City ______________ State ______ Zip______
Residence Phone #: ____-____-______________ Cellular phone/pager #: ____-____-______________
E-mail address: ______________
Referred by: ______________
Birthdate: ______________ Social Security #: ____-___-______________ TX Drivers License #: ______________
Employer: ______________ Business Phone #: ____-____-______________
Business Address: ______________ City ______________ State ______ Zip ______
If child, name of parents: ______________ If student, name of school: ______________

Spouse's Name: ______________ Spouse's Employer: ______________ Phone #:____-____-______________
Spouse's Business Address: ______________ City ______________ State ______ Zip ______

First person to contact in case of emergency: ______________ Phone #: ____-____-______________
Address: ______________ City ______________ State ______ Zip ______
Nearest relative/friend not living with you: ______________ Phone #: ____ -____-______________
Address: ______________ City ______________ State ______ Zip ______

ACCOUNT INFORMATION

Person responsible for payment: ______________ Phone #: _____-_____-______________
Are any of your family members patients? YES NO Please list: ______________
If yes, do you want to be listed under the SAME or DIFFERENT accounts
Will you need financial arrangements to help with the cost of your dental treatment? YES NO

DENTAL INSURANCE

Please fill out the following and present an insurance card(s) and/or a completed insurance form(s) to the receptionist.

Primary Dental Insurance Company: ______________ Group #: ______________
Address: ______________ City______________ State____ Zip ______ Phone #: _____-_____-______________
Policy Holder's Name: ______________ Relationship of Patient to Policy Holder: ______________
Policy Holder's Birthdate: ______________ Policy Holder's Social Security #: _____-_____-______________
Policy Holder's Employer: ______________

Secondary Dental Insurance Company: ______________ Group #: ______________
Address: ______________ City______________ State____ Zip ______ Phone #: _____-_____-______________
Policy Holder's Name: ______________ Relationship of Patient to Policy Holder: ______________
Policy Holder's Birthdate: ______________ Policy Holder's Social Security #: _____-_____-______________
Policy Holder's Employer: ______________

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am financially responsible for all charges, regardless of insurance coverage.
Responsible Party Signature: ______________ Date: ______________

MEDICAL HEALTH HISTORY (Confidential)

Name:

Name of Primary Physician: ____ Specialty: ________________________________

Address: _______________________________ City________________ State____ Zip ________ Phone #: _____-_____-_________

Please check if you have or have ever had any of the following:

CARDIOVASCULAR/BLOOD
- ____ Heart Murmur
- ____ Artificial Heart Valve
- ____ Mitral Valve Prolapse
- ____ Heart Attack/Disease
- ____ Heart Failure
- ____ Heart Surgery
- ____ Heart Pacemaker
- ____ Chest Pains/Discomfort
- ____ Circulatory Problems
- ____ Rheumatic Fever
- ____ Swollen Ankles
- ____ High Blood Pressure
- ____ Low Blood Pressure
- ____ Excessive Bleeding
- ____ Bruise Easily
- ____ Anemia
- ____ Hemophilia
- ____ Leukemia
- ____ Sickle Cell Disease
- ____ Blood Transfusion

NERVOUS SYSTEM
- ____ Stroke
- ____ Epilepsy/Convulsions
- ____ Fainting/Dizziness
- ____ Headaches
- ____ Numbness/Tingling
- ____ Nervous Disorders
- ____ Psychiatric Treatment

RESPIRATORY
- ____ Tuberculosis
- ____ Emphysema
- ____ Asthma
- ____ Hay Fever/Allergies/Hives
- ____ Persistent Cough
- ____ Shortness of Breath
- ____ Respiratory Disease

ENDOCRINE/URINARY
- ____ Diabetes
- ____ Thyroid Disease
- ____ Kidney/Bladder Trouble

DIGESTIVE
- ____ Hepatitis A (Infection)
- ____ Hepatitis B (Serum)
- ____ Jaundice
- ____ Ulcers
- ____ Liver Disease
- ____ Typhoid Fever

BONES/MUSCLES
- ____ Fractured Bones
- ____ Artificial Joints
- ____ Back Problems

EYES/EARS/NOSE/THROAT/SKIN
- ____ Glaucoma
- ____ Ringing in Ears
- ____ Sinus Problems
- ____ Frequent Nosebleeds
- ____ Scarlet Fever
- ____ Herpes/Fever Blisters
- ____ Lupus
- ____ Measles/Mumps/Chicken Pox

OTHER
- ____ AIDS/HIV Positive
- ____ Cancer
- ____ Chemotherapy/Radiation
- ____ Venereal Disease
- ____ Anorexia/Bulimia
- ____ Recent Weight Loss
- ____ Alcoholism
- ____ Drug Addiction
- ____ Surgical Implants
- ____ Other: ______________________

If you have marked any of the above, please briefly describe: ____

Please list any past hospitalizations/surgeries (minor or major): ____

Please describe any current medical treatment, impending operations, or other information that may affect your dental treatment:

____

MEDICATIONS

List medications you are currently taking: ________________

____

Pharmacy Name: _______________ Phone #: ______________

ALLERGIES TO MEDICATIONS

- ____ Penicillin
- ____ Codeine
- ____ Aspirin
- ____ Sulfa
- ____ Barbiturates
- ____ Local Anesthesia
- ____ Other: __________________

Have you ever been premedicated for your dental appointments in the past? YES NO

Do you frequently drink alcohol? YES NO Do you smoke tobacco? YES NO Do you use smokeless tobacco? YES NO

<u>For Women</u>: Are you pregnant? YES NO Due Date: ___________ Nursing? YES NO Taking Birth Control Pills? YES NO

DENTAL HEALTH HISTORY (Confidential)

Name:

Previous Dentist: ____ Specialty: _________________________________

Address: _______________________________ City____________ State____ Zip ________ Phone #: ____-____-________________

Date of last cleaning and exam: ________________________ Date of last full mouth x-rays: ______________________

Reason for changing dentists: ____

Have you ever had an unfavorable experience at a dental office? YES NO Briefly describe: __________________________________

____

Are you nervous about receiving dental treatment today? YES NO

IMMEDIATE DENTAL CONCERN: ____

Please check if you have experienced any of the following:

____ Periodontal/gum disease
(How long ago? ___)
____ Bleeding gums
____ Receding gums
____ Swelling of the gums
____ Pain or soreness in gums
____ Growths or swellings in mouth
(How long existed? ____)
____ Spaces between teeth
____ Drifting teeth

____ Loose teeth
____ Food packing between teeth
____ Infection around teeth
____ High or rough fillings
____ Bad breath or taste in mouth
____ Sensitivity to: __ hot __ cold
__ pressure __biting
__ chewing __ tooth brushing
__ sweets
____ Clenching/grinding teeth

____ Jaw clicking or popping
____ Stiff neck muscles
____ Pain/soreness around eyes, ears, jaw area
____ Tension headaches
____ Difficulty in opening/closing mouth
____ Difficulty in chewing/swallowing

How often do you brush your teeth? ________________
floss your teeth? ________________
Do you use a supplemental fluoride rinse/gel at home? ________ What kind? ____________________________
List any additional dental aids you use at home (i.e. electric toothbrush) ____

Have you ever lost any teeth? YES NO From what cause? ____
Have you ever injured your mouth/teeth in an accident? YES NO Briefly describe: ____
____
Have you had any orthodontic work? YES NO How long ago? _____________________________
Have you had oral surgery? YES NO How long ago? ________ Describe: _____________________________________
Have you had any periodontal treatment? YES NO How long ago? ______ Describe: _________________________________
Do any of your family members wear dentures/partials? YES NO

IF YOU WEAR A PARTIAL OR DENTURE, PLEASE COMPLETE THE FOLLOWING:
What type of partial/denture do you have? UPPER LOWER BOTH
How long have you worn a partial/denture? ____
Are you satisfied with the appearance? ______ comfort? _______ chewing ability? _________ your speech? ________

COSMETIC DENTISTRY

Please check any of the following cosmetic alternatives you might be interested in:

____ Teeth straightening
____ Replacing silver fillings with tooth colored fillings
____ Teeth whitening
____ Bonding
____ Porcelain veneers
____ Filling spaces
____ Improving the overall appearance of your smile

The above information is accurate and complete to the best of my knowledge. If any change occurs in my dental and/or medical health, I will report it to this office as soon as possible. I understand that I am and/or my parent or guardian is financially responsible for all fees related to my dental treatment.
Patient Signature: ____ Date: __________________________
Responsible Party Signature: ________________________________ Date: ____________________________