BROOKS ORTHODONTICS

embrace your smile

PATIENT NAME [ADULT]

7684 6/17

LAST _____ FIRST _____ MIDDLE _____

D.O.B. / / ☐ MALE ☐ FEMALE

PREFERRED NAME: _____ **SSN:** _____

ADDRESS: _____
STREET CITY STATE ZIP

Cell Phone: _____ Other Phone: _____

Patient's Dentist: _____ Last Visit: _____

Patient's Physician: _____ Last Visit: _____

Employer: _____ Marital Status: _____

Whom may we thank for referring you to us? _____

Do you plan to relocate out of the area in the near future? Y N If so, when? _____

Which office location is most convenient to you? ☐ Pensacola ☐ Pace ☐ Jay

Is the patient under any medical treatment now? Y N If so, what? _____

List any medications you are currently taking: _____

List any drug allergies/sensitivities: _____

List any history of serious illness, accident, surgery, or other condition: _____

List any injury/trauma the patient has had to his/her jaws: _____

HAS THE PATIENT HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Y N HEAD OR FACIAL INJURY
Y N TONSILLITIS
Y N HEPATITIS/LIVER DISEASE
Y N RHEUMATIC FEVER
Y N HIV/AIDS
Y N KIDNEY DISEASE
Y N ALLERGIES OR ASTHMA
Y N METAL ALLERGIES
Y N HEART MURMUR/PROBLEMS
Y N ARTHRITIS
Y N VENEREAL DISEASE
Y N EPILEPSY/SEIZURES
Y N BLEEDING PROBLEMS
Y N DIABETES
Y N EAR INFECTIONS
Y N OSTEOPOROSIS
Y N CANCER/CHEMOTHERAPY
Y N HEARING DISORDER
Y N HIGH BLOOD PRESSURE
Y N EMOTIONAL PROBLEMS
Y N NERVOUS PROBLEMS
Y N ENDOCRINE PROBLEMS
Y N JAW JOINT PAIN (TMJ)

Have you been informed of any missing or extra permanent teeth? _____

Has an orthodontist been consulted previously or have you had previous orthodontic treatment?
Y N If so, by whom? _____

What part of your orthodontic problem concerns you most? _____

_____

_____

Additional information you feel would make your experience with us more enjoyable: _____

_____

_____

The information I have given today is correct to the best of my knowledge. I understand that this information will be held in strictest confidence, and it is my responsibility to inform this office of any changes in my medical status.

K. Glenn Brooks
DDS, MS, PA

BOARD CERTIFIED AMERICAN BOARD OF ORTHODONTICS ABO

_____ / /
PATIENT'S SIGNATURE DATE