R. Merritt Brown
Doctor of Dental Medicine
58 Lafayette Avenue, Morristown, New Jersey 07960

Welcome!

We are very glad you have selected our office for your dental care.
An essential part of our approach is a thorough health history. So that we may provide you with the best possible care, please complete this medical/dental history form.
Thank you! *All information is completely confidential.*

Patient Registration (*please print*) **Date** _____

Home Phone _____ **Cell** _____ **E-mail** _____

Patient Last Name _____ **First Name** _____ **Initial** _____ **Preferred Name** _____

Home Street Address _____ **City** _____ **State** _____ **Zip** _____

Sex: ❑ M ❑ F Age _____ Birthdate _____ Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Spouse's Last Name _____ First Name _____ Initial _____ Preferred Name _____

Spouse Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Who is responsible for this account? _____ Relationship to Patient _____

Social Security # _____ Spouse's Social Security # _____

Name of Primary Dental Insurance Company _____ Group Number _____

Name of Secondary Dental Insurance Company _____ Group Number _____

In Case of Emergency, who should be notified? _____ Phone _____

Whom may we thank for referring you to our office: _____

Medical Alerts

Need for Medical Consult _____ Need for Antibiotic Premedication _____

What is the reason for your visit today? _____

MEDICAL HISTORY

Blood Pressure: _____ /_____ Pulse: _____

General health: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Name, address and phone # of physician _____

Last complete physical? _____

Have you ever been treated *(other than diagnostic)* with x-ray? _____ ❑ Yes ❑ No

Are you allergic or sensitive to any of these medications: ❑ Penicillin? ❑ Codeine? ❑ Local Injected Anesthetics?

Are you allergic or sensitive to any other medications or substances? What? _____ ❑ Yes ❑ No
(Alcohol, Penicillin, Codeine, Metal, Acrylic, Latex Rubber, Etc.?)

Have you ever been treated for osteoporosis? _____ ❑ Yes ❑ No

Are you under a doctor's care now? Why? _____ ❑ Yes ❑ No

Have you been hospitalized or received a blood transfusion? When? _____ ❑ Yes ❑ No

Are you taking any medications, pills, or drugs? What? _____ ❑ Yes ❑ No

Please *circle* if you have had any of the following:

Scarlet Fever	Cancer	Hypoglycemia	Parathyroid Disease	Drug Addiction
Asthma	Thyroid Disease	Psychiatric Care	X-ray or Cobalt Tmt.	Blood Transfusion
Heart Trouble	Chest Pain	Hay Fever	Chemotherapy/Radiation	Hemophilia
High Blood Pressure	Shortness of Breath	Sinus Trouble	Arthritis/Gout	AIDS (HIV)
Low Blood Pressure	Swelling of Feet/Ankles/Hands	Emphysema	Rheumatism	Venereal Disease
Heart Murmur	Fainting or Dizziness	Frequent Cough	Pain in Jaw Joints	Cold Sores
Rheumatic Fever	Stroke	Lung Disease	Cortisone Medicine	Fever Blisters
Congenital Heart Lesion	Diabetes	Tuberculosis	Glaucoma	Herpes
Artificial Heart Valve	Excessive Thirst	Liver Disease	Epilepsy or Seizures	Bruise Easily
Heart Pacemaker	Artificial Joints/Hips	Hepatitis A (infec.)	Nervousness	Sickle Cell Anemia
Heart Surgery	Kidney Trouble	Hepatitis B (serum)	Alzheimer's Disease	Mitral Valve Prolapse
Blood Disease	Ulcers	Yellow Jaundice		
Anemia	Allergies	Recent Weight Loss		

Have you ever had any other serious illness not circled above? _____ ❑ Yes ❑ No

Please describe in detail _____

Do you wish to talk to the doctor privately about any problem? _____ ❑ Yes ❑ No

(Women) Are you pregnant? _____ ❑ Yes ❑ No

If yes, _____
Expected Delivery Date

Dental History

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? *(Interplak, toothpick, etc.)* _____

Do you have any dental problems now? ❑ Yes ❑ No

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or Cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other lesions?	Yes	No

Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite you lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? *(pencils, pipe, pins, nails, fingernails)*	Yes	No
Mouth breath while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No
Is there anything else about having dental treatment that you would like us to know?	Yes	No

If yes, please describe _____

_____

_____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

Have you ever had:

Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause _____

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? *(joint, ear, side of face)*	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles? *(neck, shoulders)*	Yes	No

Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If so, what is your biggest concern? _____

_____

Have you ever had an upsetting dental experience?	Yes	No

If yes, please describe _____

_____

_____

_____

_____

_____

_____

X _____ Date _____

Patient Signature (Parent or Guardian)

Reviewed by: Doctor _____ Date _____

Medical History Update

Has there been any change in your health since your last dental appointment? ❑ Yes ❑ No Blood Pressure: ______ /______ Pulse: ________

For what condition? ____________________

Are you taking any new medications? If so, what? ____________________

Date ____________________ Signature ____________________

Date ____________________ Doctor's Signature ____________________

Has there been any change in your health since your last dental appointment? ❑ Yes ❑ No Blood Pressure: ______ /______ Pulse: ________

For what condition? ____________________

Are you taking any new medications? If so, what? ____________________

Date ____________________ Signature ____________________

Date ____________________ Doctor's Signature ____________________

Has there been any change in your health since your last dental appointment? ❑ Yes ❑ No Blood Pressure: ______ /______ Pulse: ________

For what condition? ____________________

Are you taking any new medications? If so, what? ____________________

Date ____________________ Signature ____________________

Date ____________________ Doctor's Signature ____________________

Has there been any change in your health since your last dental appointment? ❑ Yes ❑ No Blood Pressure: ______ /______ Pulse: ________

For what condition? ____________________

Are you taking any new medications? If so, what? ____________________

Date ____________________ Signature ____________________

Date ____________________ Doctor's Signature ____________________

Has there been any change in your health since your last dental appointment? ❑ Yes ❑ No Blood Pressure: ______ /______ Pulse: ________

For what condition? ____________________

Are you taking any new medications? If so, what? ____________________

Date ____________________ Signature ____________________

Date ____________________ Doctor's Signature ____________________