Robert C. Brooks D.D.S 1511 Eighth Street Winnsboro, LA 71295

(318) 435-4648

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient #

| PATIENT INFORMATION  Name  |                              | Date              |                    |   |                    |       |
|--|------------------------------|-------------------|--------------------|---|--------------------|-------|
| Address  | PATIENT INFORI               | MATION            |                    |   |                    |       |
| Sex M F Married Widowed Single Minor  "Separated Divorced Partnered for  | Name                         |                   | Birthdate _        |   | SS#                |       |
| Separated   Divorced   Partnered foryears   Email  |                              |                   | City               |   | State              | _ Zip |
| Home Phone Cell Phone Employer Address City State Zip Shouse or Parent's Name Employer Address City State Zip Work Phone Employer Address City Shouse or Parent's Name Employer Work Phone Work Phone Work Phone Work Phone Person to contact in case of emergency Phone RESPONSIBLE PARTY  Name of Insured Social Security # Date Employed Employer Work Phone Birthdate Social Security # State Zip Max. Annual Benefit Address City State Zip Date Employer Address Address Address Annual Benefit Date Employer Social Security # Date Employed State Zip Max. Annual Benefit Address Address City State Zip Date Employer Address City State Zip Date Employer Address Social Security # Date Employed State Zip Max. Annual Benefit Address City State Zip Date Employer Address Social Security # Date Employed State Zip Max. Annual Benefit Address Social Security # Date Employed State Zip Max. Annual Benefit Address Social Security # Date Employed State Zip Max. Annual Benefit Address Social Security # Date Employed State Zip Max. Annual Benefit Address Social Security # Date Employed State Zip Social Security # Date Employed State Zip Max. Annual Benefit Address Social Security # Date Employed State Zip Social Security # State Zip Social Securi | Sex ·· M ·· F ·· M           | arried Widowed    | ·· Single          | · · Minor                                 |                    |       |
| Home Phone   | <br>Se                       | eparated Divorced | · · Partner        | ed for years                              |                    |       |
| Employer Address   | Home Phone                   | Cell Ph           | one                |   | Email              |       |
| Spouse or Parent's Name  | Employer                     |                   |                    | Employer Phone                            |                    |       |
| Whom may we thank for referring you?  Person to contact in case of emergency Phone Preson to contact in case of emergency Phone Preson RESPONSIBLE PARTY  Name of Person Responsible for this Account Relation to Patient Address Home Phone Birthdate Currently a patient in our office? "Yes "No Employer Work Phone Person Relation to Subscriber Person Person Person Person Relation to Subscriber Person Per | Employer Address             |                   | City               |   | State              | _ Zip |
| Person to contact in case of emergency Phone  RESPONSIBLE PARTY  Name of Person Responsible for this Account Relation to Patient Home Phone  Birthdate Currently a patient in our office? '' Yes '' No  Employer Work Phone  E-Mail Cell Phone  DENTAL INSURANCE INFORMATION  Name of Insured Relation to Subscriber  Birthdate Social Security # Date Employed State Zip  Insurance Company Group # Subscriber ID  Address City State Zip  How much is your deductible? How much have you used? Relation to Subscriber  Birthdate Social Security # Date Employed State Zip  How much is your deductible? How much have you used? Max. Annual Benefit  ADDITIONAL DENTAL INSURANCE  Relation to Subscriber  Birthdate Social Security # Date Employed  Relation to Subscriber State Zip  How much so your deductible? How much have you used? State Zip  Insurance Company Social Security # Date Employed  Employer State Zip  Insurance Social Security # State Zip  Insurance Company State Zip  | Spouse or Parent's Name _    |                   | Employer _         |   | Work Phone         |       |
| RESPONSIBLE PARTY Name of Person Responsible for this Account Address Home Phone Birthdate Currently a patient in our office? "Yes "No Employer Work Phone E-Mail DENTAL INSURANCE INFORMATION Name of Insured Birthdate Social Security # Date Employed Employer Work Phone #  Employer Address City How much is your deductible? ADDITIONAL DENTAL INSURANCE  Relation to Subscriber Birthdate Social Security # Date Employed  Employer Birthdate Social Security # Subscriber ID Address Relation to Subscriber  Brand Employed  Employer Brand Br | Whom may we thank for refe   | erring you?       |                    |   |                    |       |
| Name of Person Responsible for this Account Address  | Person to contact in case of | emergency         |                    | Phone                                     |                    |       |
| Responsible for this Account Address Home Phone Birthdate Currently a patient in our office? "Yes "No Employer Work Phone E-Mail Cell Phone  DENTAL INSURANCE INFORMATION  Name of Insured Relation to Subscriber Birthdate Social Security # Date Employed Employer Address City State Zip How much is your deductible? How much have you used? Max. Annual Benefit  ADDITIONAL DENTAL INSURANCE  Birthdate Social Security # Date Employed  Employer Address City State Zip  Max. Annual Benefit  ADDITIONAL DENTAL INSURANCE  Name of Insured Relation to Subscriber Birthdate Social Security # Date Employed  Employer Address Social Security # Date Employed  Employer Address Social Security # State Zip  Max. Annual Benefit  ADDITIONAL DENTAL INSURANCE  Name of Insured Relation to Subscriber  Birthdate Social Security # Date Employed  Employer Address City State Zip Insurance Company Group # Subscriber ID  Address City State Zip  Insurance Company Subscriber ID  Address City State Zip  Insurance Company Subscriber ID  Address City State Zip  |                              | ARTY              |                    |   |                    |       |
| Address Home Phone Currently a patient in our office? "Yes "No Employer Work Phone E-Mail Cell Phone  DENTAL INSURANCE INFORMATION  Name of Insured Relation to Subscriber  Birthdate Social Security # Date Employed  Employer Address City State Zip  How much is your deductible? How much have you used? Max. Annual Benefit  ADDITIONAL DENTAL INSURANCE  Birthdate Social Security # Date Employed  Employer Address City State Zip  How much is your deductible? How much have you used? Max. Annual Benefit  Employer Address City State Zip  How much Insured Relation to Subscriber  Birthdate Social Security # Date Employed  Employer Address City State Zip  Address Social Security # Subscriber State Zip  Birthdate Social Security # State Zip  How reployer Address State Zip  Insurance Company Group # Subscriber ID  Address City State Zip  Address Zip  |                              | t                 |                    | Relation to Patient                       |                    |       |
| Employer   |                              |                   |                    |   |                    |       |
| E-Mail Cell Phone  | Birthdate                    |                   |                    | Currently a patient in our office? Yes No |                    |       |
| DENTAL INSURANCE INFORMATION  Name of Insured  | Employer                     |                   |                    | Work Phone                                |                    |       |
| Name of Insured  | E-Mail                       |                   |                    | Cell Phone                                |                    |       |
| Birthdate  | DENTAL INSURA                | NCE INFORMAT      | ION                |   |                    |       |
| Employer         Work Phone #           Employer Address         City         State         Zip           Insurance Company         Group #         Subscriber ID           Address         City         State         Zip           How much is your deductible?         How much have you used?         Max. Annual Benefit           ADDITIONAL DENTAL INSURANCE           Name of Insured         Relation to Subscriber           Birthdate         Social Security #         Date Employed           Employer         Work Phone #           Employer Address         City         State         Zip           Insurance Company         Group #         Subscriber ID           Address         City         State         Zip  | Name of Insured              |                   |                    | Relation to Subscriber                    |                    |       |
| City   | Birthdate                    | Social S          | Security #         |   | Date Employed      |       |
| Subscriber ID  | Employer                     |                   |                    | Work Phone #                              |                    |       |
| Address  | Employer Address             |                   | City               |   | State              | Zip   |
| How much is your deductible? How much have you used? Max. Annual Benefit   | Insurance Company            |                   | Group #            |   | Subscriber ID      |       |
| ADDITIONAL DENTAL INSURANCE  Name of Insured   | Address                      |                   | City               |   | State              | Zip   |
| ADDITIONAL DENTAL INSURANCE  Name of Insured   | How much is your deductible  | e? How mu         | uch have you used? |   | Max. Annual Benefi | t     |
| Birthdate  |                              |                   |                    |   |                    |       |
| Birthdate  | Name of Insured              |                   |                    | Relation to Subscriber                    |                    |       |
| Employer   |                              |                   |                    |   |                    |       |
| Employer Address         City         State         Zip           Insurance Company         Group #         Subscriber ID           Address         City         State         Zip   |                              |                   |                    |   |                    |       |
| Insurance Company         Group #         Subscriber ID           Address         City         State         Zip   |                              |                   |                    |   |                    |       |
| Address City State Zip   |                              |                   |                    |   |                    |       |
|  |                              |                   |                    |   |                    |       |
| How much is your deductible? How much have you used? Max. Annual Benefit   |                              |                   |                    |   |                    |       |

| DENTAL HISTORY   |   |  |  |  |
|--|---|--|--|--|
| Reason for today's visit   |   | Date of last dental care   |  |  |
| Former Dentist   |   | Date of last dental X-rays   |  |  |
| Address  |   |  |  |  |
| Check ( ¡;) if you have or have had pro  |   |  |  |  |
| Bad Breath   | Grinding Teeth  |  | Sensitivity to hot   |  |
| ☐ Bleeding Gums ☐ Loose teeth or br  |   | ten fillings Sensitivity to sweets   |  |  |
| ☐ Clicking or popping jaw  | licking or popping jaw  |  | Sensitivity when biting  |  |
| Food collecting between the teet   | ☐ Food collecting between the teeth ☐ Sensitivity to cold   |  | ☐ Sores or growths in your mouth   |  |
| How often do you floss?  |   | How often do you brush?  |  |  |
| MEDICAL HISTORY  |   |  |  |  |
| Physician's Name   |   | Date of last visit   |  |  |
| Have you ever taken any of the group names of phentermine), Pndimin (fenfl   |   |  | s of Ionimin, Adipex, Fastin (brand  |  |
| Have you ever had any serious illness  | es or operations??  | If yes, describe   |  |  |
| Have you ever had a blood transfusion  | i? □Yes □No   | If yes, give approximate dates   |  |  |
| (Women) Are you pregnant?  | es No Nursing? Yes  | s ☐ No Taking birth  | control pills? ☐Yes ☐No  |  |
| Check (Ü) if you have or have had pro  | oblems with any of the following:   |  |  |  |
| Anemia Arthritis, Rheumatism Artificial Heart Valves Artificial Joints, Pins, etc. Asthma Back Problems Bleeding Abnormally Blood Disease Cancer Chemical Dependency Chemotherapy Circulatory Problems  List medications you are currently takin | Congenital Heart lesions Cortisone Treatments Cough, Persistent Cough up Blood Diabetes Epilepsy Fainting Glaucoma Headaches Heart Murmur Heart Problems Hemophilia | Hepititis Hernia Repair High Blood Pressure HIV/AIDS Jaw Pain Kidney Disease Liver Disease Mitral Valve Prolapse Pacemaker Radiation Treatment Respiratory Disease Rheumatic fever | Scarlet Fever Shortness of Breath Skin Rash Stroke Swelling of Feet or Ankl Thyroid Problems Tobacco Habit Tonsillitis Tuberculosis Ulcer Venereal Disease |  |
| Allergies:   |   |  |  |  |
| <ul><li>Aspirin</li><li>Barbiturates (Sleeping Pills)</li><li>Codeine</li></ul>  | ·· Local Anesthetic ·· Penicillin ·· Sulfa  | ··· lodine ··· Latex ··· None  | ·· Other   |  |
| To the best of my knowledge, the above mindor child, ever have a change in he  |   | . I understand that it is my responsibi  | ility to inform my doctor if I, or my  |  |
| Signature of of  | Date  |  |  |  |
| Please print name  | Relationship to Patient   |  |  |  |