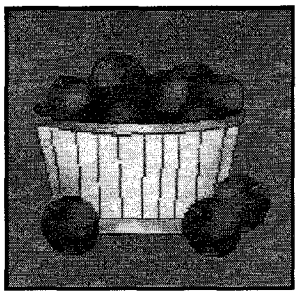

W. Timothy Brooks, D.M.D., M.A.G.D.
500 Whitesport Drive Suite 3
Huntsville, Alabama 35801
(256) 883-8008

Patient Information

Patient Name:_____ Date:_____
Last First MI Preferred Name

Address:_____
Street City/State Zip code

Sex (M or F) _____ Marital Status_____ Birth Date_____

Phone: Home_____ Cell_____

Employer_____ Work Phone_____

Email Address_____ Social Security #_____

Whom may we thank for referring you?_____

Person to contact in case of emergency_____ Phone_____

Insurance Information

Primary

Subscriber Name_____ SS#_____ Birth Date_____

Insurance Company_____ Group Number _____

Mailing Address_____ Effective Date_____

Employer Name_____ Work Phone _____

Secondary

Subscriber Name_____ SS#_____ Birth Date_____

Insurance Company_____ Group Number _____

Mailing Address_____ Effective Date_____

Employer Name_____ Work Phone _____

Responsible Party

Person responsible for this account_____ Relationship_____

Address_____
Street City/State/Zip Code

Home Phone_____ Cell_____

Employer_____ Work Phone _____

Dental History

Reason for today's visit_____ Date of last visit_____

Former Dentist _____Date of last dental x-rays_____

Check if you have had problems with any of the following:

Bad breath	Bleeding gums	Clicking or popping jaw	Grinding teeth
Periodontal treatment	Sensitivity to cold	Sensitivity to sweets	Sensitivity to hot
Loose teeth or broken fillings	Food collection between teeth	Sores or growths in your mouth	Sensitivity when biting

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

Health Information

Physician_____ Office Phone_____ Date of last exam_____

Do you have any of the following conditions? Please check all those that apply:

☐ Abnormal Bleeding	☐ Alcohol Abuse	☐ Allergies
☐ Anemia	☐ Angina Pectoris	☐ Arthritis
☐ Artificial Bones	☐ Artificial Heart Valve	☐ Asthma
☐ Blood Transfusion	☐ Cancer-Chemotherapy	☐ Colitis
☐ Congenital Heart Defect	☐ Cosmetic Surgery	☐ Diabetes
☐ Difficulty Breathing	☐ Drug Abuse	☐ Emphysema
☐ Epilepsy	☐ Fainting Spells	☐ Fever Blisters
☐ Hay Fever	☐ Heart Attack	☐ Heart Surgery
☐ Hepatitis A	☐ Hepatitis B	☐ High Blood Pressure
☐ HIV+ AIDS	☐ Kidney Problems	☐ Liver Disease
☐ Low Blood Pressure	☐ Mitral Valve Prolapse	☐ Pace Maker
☐ Pneumocystitis	☐ Psychiatric Problems	☐ Radiation Therapy
☐ Rheumatic Fever	☐ Seizures	☐ Shingles
☐ Sickle Cell Disease	☐ Sinus Problems	☐ Stroke
☐ Thyroid Problems	☐ Tuberculosis	☐ Ulcers
☐ Gerd/Acid Reflux	☐ Glaucoma	☐ Frequent Headaches
☐ Persistent cough	☐ Hemophilia	

Do you use tobacco? _____

Allergies

Aspirin	Codeine
Dental Anesthetics	Erythromycin
Jewelry	Latex
Metals	Penicillin
Tetracycline	
Other	

_____

_____

Please list all medications you are currently taking Or provide a list

_____

_____

_____

_____

_____

_____

_____

Women Only:

Are you pregnant or think you may be pregnant? _____ Number of weeks? _____

Are you nursing? _____ Are you taking oral contraceptives? _____

Bite and Jaw Joint

Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)
yes no
Do you feel like your lower jaw is being pushed back when you bite your teeth together?
yes no
Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?
yes no
Have your teeth changed in the last 5 years, become shorter, thinner, or worn?
yes no
Are your teeth becoming more crooked, crowded, overlapped?
yes no
Are your teeth developing spaces or becoming more loose?
yes no
Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together?
yes no
Do you place your tongue between your teeth or close your teeth against your tongue?
yes no
Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?
yes no
Do you clinch your teeth in the daytime or make them sore?
yes no
Do you have any problems with sleep (i.e. restlessness), wake up with a headache or awareness of your teeth?
yes no
Do you wear or have your ever worn a bite appliance?
yes no

Authorization and Release

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to Dr. W. Timothy Brooks all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. W. Timothy Brooks may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year form the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

I understand that where appropriate, credit bureau reports may be obtained. _____
Signature (Parent's, if minor)