MICHAEL D BROOKS, DMD, MS, PLLC
MICHAEL J BOWMAN, DDS, MS, PLLC

PATIENT INFORMATION RECORD

NAME____ DATE__________________

DATE OF BIRTH_______________ SEX______SOCIAL SECURITY___________________

HOME ADDRESS_______________________________HOME PH___________________

____ EMAIL __________________

CITY STATE ZIP

EMPLOYER___________________________________ OTHER PH___________________

DENTAL INSURANCE

____

PRIMARY SUBSCRIBER NAME SOCIAL SECURITY # DATE OF BIRTH

____

INSURANCE CO. NAME GROUP # PHONE NUMBER

____

INSURANCE CO. ADDRESS CITY STATE ZIP

____

SUBSCRIBER NAME SOCIAL SECURITY # DATE OF BIRTH

____

INSURANCE CO. NAME GROUP # PHONE NUMBER

____

INSURANCE CO. ADDRESS CITY STATE ZIP

SPOUSE/PARENT NAME_______________________________DOB_________________

SPOUSE/PARENT EMPLOYER_________________________ WORK #_______________

REFERRED BY____

PURPOSE FOR YOUR VISIT ____

As a courtesy to our patients with allergies, we ask that you refrain from using perfume or cologne when you come to your appointments. Your understanding is greatly appreciated.

x____

SIGNATURE OF PATIENT/GUARDIAN DATE

MICHAEL D BROOKS, DMD, MS, PLLC
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Medical History

PATIENT NAME: ____

Have you been under the care of a medical practitioner during the past two years? YES NO

If YES, for what? ____

PHYSICIANS'S NAME ______________________ PHONE ____________

ADDRESS ____

DATE OF LAST MEDICAL EXAM: ______________________________

PLEASE LIST ALL MEDICATIONS/DRUGS YOU ARE CURRENTLY TAKING: (Name, strength & dosage)

____

____

____

Have you been hospitalized or had any operations? ______________________

Have you become sick, shown an ALLERGY to, or been told not to take any of the following:

YES NO - PENICILLIN OR OTHER ANTIBIOTICS
YES NO - ASPIRIN, CODEINE OR OTHER PAIN MEDICATIONS
YES NO - NOVOCAIN, XYLOCAINE OR OTHER MEDICATIONS

LIST ALL KNOWN ALLERGIES: ______________________________

____

YES NO - Do you smoke? How much? _________ per DAY or WEEK
YES NO - Daily alcohol intake ____________________

WOMEN: Are you PREGNANT? YES _____ Months NO NURSING? YES NO
Taking BIRTH CONTROL PILLS? YES NO

COMPLETE THIS SECTION IF YOU ARE PRESENTLY WEARING DENTURES OR PARTIALS

DENTURE/PARTIAL HISTORY

Are you presently wearing dentures/partials? Upper?____________Lower?______________
(Year Made) (Year Made)

Are you happy with your current prosthesis, if not please explain?

____

____

DR. MICHAEL D. BROOKS, DMD, MS, PLLC
DR. MICHAEL J. BOWMAN, DDS, MS, PLLC

PLEASE b WHICH OF THE FOLLOWING YOU HAVE HAD OR HAVE AT THE PRESENT:

n Heart surgery, disease, attack
n Chest pain
n Congenital heart disease
n Heart murmur
n Mitral Valve prolapse
n Artificial heart valve
n Rheumatic fever or rheumatic heart disease
n Heart pacemaker
n High blood pressure
n Arthritis, rheumatism
n Cortisone medication
n Swollen ankles
n Stroke
n Diet – special/restricted
n Artificial joint
n Kidney trouble
n Ulcers
n Diabetes
n Thyroid problems
n Glaucoma
n Contact lenses
n Emphysema
n Chronic cough
n Tuberculosis
n Asthma
n Herpes

n Latex sensitivity
n Allergies or hives
n Sinus trouble
n Radiation therapy
n Chemotherapy
n Tumors
n Hepatitis A-infectious/Hepatitis B -serum/Hepatitis C
n Venereal disease
n AIDS
n HIV positive
n Cold sores/fever blisters
n Blood transfusions
n Hemophilia
n Sickle cell disease
n Anemia
n Bruise easily
n Prolonged bleeding after injury or surgery
n Liver disease
n Yellow jaundice
n Neurological disorders
n Epilepsy or seizures
n Fainting/dizzy spells
n Nervous/anxious
n Psychiatric/psychological care
n Osteoporosis

Do you have any disease, condition or problems that haven't been listed?
Please list: ____

____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further

information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health and/or medication.

PATIENT/GUARDIAN SIGNATURE

____

Signature Date

MICHAEL D BROOKS, DMD, MS, PLLC
MICHAEL J BOWMAN, DDS, MS, PLLC

19365 7th Avenue N.E., Suite 114
Poulsbo, WA. 98370
(360) 779-7414

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I am aware of my rights to privacy regarding my protected health information, under the Health Insurance Portability & accountability Act of 1996 (HIPAA). I understand that this information can and will be used for:

- ❑ Provide and coordinate my treatment among a number of health care providers who may be involved in the treatment directly and indirectly.
- ❑ Obtain payment from third-party payers for my health care services.
- ❑ Conduct normal health care operations such as quality assessment and improvement activities.

Please list any other person(s) that we may share your information with:

____

____

Please note that a copy the *Notice of Privacy Practices* which contains a complete description of the uses and disclosures of my protected health information is available upon request. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Signature: ___________________________Date: __________________

If signing for a patient, your relationship to Patient: ____________________________

For office use only:
We were unable to obtain the patient’s written acknowledgement of our *Notice of Privacy Practices* due to the following reason:

- ❑ The patient refused to sign.
- ❑ Communication barriers
- ❑ Emergency situation