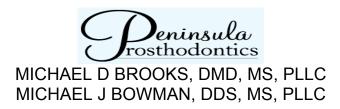


# MICHAEL D BROOKS, DMD, MS, PLLC MICHAEL J BOWMAN, DDS, MS, PLLC

#### **PATIENT INFORMATION RECORD**

| NAME                    |                                                                                       | DATE_                                      |                                |
|-------------------------|---------------------------------------------------------------------------------------|--------------------------------------------|--------------------------------|
| DATE OF BIRTH           | SOCI                                                                                  | AL SECURITY                                |                                |
| HOME ADDRESS            |                                                                                       | HOME PH                                    |                                |
|                         |                                                                                       | EMAIL _                                    |                                |
|                         | ATE ZIP                                                                               |                                            |                                |
| EMPLOYER                |                                                                                       | OTHER PH_                                  |                                |
|                         | DENTAL INS                                                                            | URANCE                                     |                                |
| 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 EMPLOYE   | ER                                                                                    | WORK #                                     |                                |
| REFERRED BY             |                                                                                       |                                            |                                |
| PURPOSE FOR YOUR VISIT  |                                                                                       |                                            |                                |
| As a court              | esy to our patients with all<br>perfume or cologne when y<br>Your understanding is gi | lergies, we ask that<br>you come to your a | t you refrain<br>appointments. |
| X                       |                                                                                       |                                            |                                |



### **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 NAMEPHONE                                                                                                                         |  |  |  |
| 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?                                                                                              |  |  |  |
| YES NO - PENICILLIN OR OTHER ANTIBIOTICS YES NO - ASPIRIN, CODEINE OR OTHER PAIN MEDICATIONS YES NO - NOVOCAIN, XYLOCAINE OR OTHER MEDICATIONS |  |  |  |
| LIST <u>ALL</u> 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
- Congenital heart disease
- n Heart murmur
- Mitral Valve prolapse
- Artificial heart valve
- Rheumatic fever or rheumatic heart disease
- n Heart pacemaker
- n High blood pressure
- n Arthritis, rheumatism
- Cortisone medication
- Swollen ankles
- n Stroke
- n Diet special/restricted
- Artificial joint
- M Kidney trouble
- **n** Ulcers
- n Diabetes
- Thyroid problems
- n Glaucoma
- Contact lenses
- n Emphysema
- Chronic cough
- n Tuberculosis
- n Asthma
- n Herpes

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

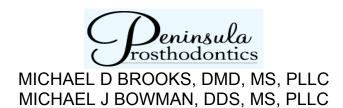
| Do you have any diseas | e, condition or problems that haven't been listed? |  |
|------------------------|----------------------------------------------------|--|
| Please list:           |                                                    |  |

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 |
|-----------|------|



19365 7<sup>th</sup> 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 <i>Notice of Privacy Pract</i> description of the uses and disclosures of my prote upon request. I understand that my dental provider <i>Privacy Practices</i> and that I may contact this office current copy of the <i>Notice of Privacy Practices</i> . | cted health information is available has the right to change the <i>Notice of</i> |  |  |
| I understand that I may request in writing that you rused or disclosed to carry out treatment, payment of understand that you are not required to agree to my agree then you are bound to abide by such restriction.                                                                   | or health care operations and I<br>y requested restrictions, but if you do        |  |  |
| 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