(PLEASE PRINT)

PATIENT REGISTRATION AND MEDICAL HISTORY

Brodie Dental, L.L.C.
Scott W. Brodie, D.M.D.
305 Shafer Lane
Jacksonville, OR 97530

Date: _____ Confirmation Type: ❑ Email ❑ Text ❑ Call

Home Phone _____ Cell Phone _____ Email _____

Patient _____
Last Name First Name Initial Preferred Name

Mailing Address _____ City _____ State _____ Zip _____

Street Address _____ City _____ State _____ Zip _____

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

Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Spouse Name _____ Spouse Birthdate _____

Spouse Employed by _____ Occupation _____

Business Address _____ Business Phone _____

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

Patient Social Security # _____ Spouse's Social Security # _____

Name of Dental Insurance Company _____ Group Number _____

In case of emergency, who should be notified? _____ Phone _____

Whom may we thank for referring you? _____ Family Members _____

MEDICAL HISTORY

Physicians Name _____ Date of Last Physical _____

Have you ever had any of the following? (check boxes that apply):

❑ Heart Problems
❑ High Blood Pressure
❑ Low Blood Pressure
❑ Circulatory Problems
❑ Nervous Problems
❑ Radiation Treatment
❑ Artificial Heart Valves or Joints
❑ Recent Weight Loss
❑ Back Problems
❑ Diabetes Type? _____
❑ Respiratory Disease
❑ Asthma
❑ Epilepsy
❑ Headaches
❑ Hepatitis, Jaundice or Liver Disease
❑ Cancer
❑ Psychiatric Care
❑ Allergies to Anesthetics
❑ Latex Allergy
❑ Blood Disease
❑ Arthritis
❑ Special Diet
❑ COPD
❑ Swollen Neck Glands
❑ Sinus Problems
❑ HIV
❑ Immunosuppressive Disorders
❑ Stroke
❑ Ulcer
❑ Sexually Transmitted Infection
❑ Chemical Dependency
❑ Hemophilia

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____ Please specify _____

Are you taking or have you ever taken bisphosphonates? (medication to prevent loss of bone and asteoporosis, ie. Fosamax and Boniva) _____

Are you taking any medication at this time? _____ Please specify _____

Have you ever responded adversely to medical or dental treatment? _____

Do you use Tobacco products? ❑ Yes ❑ No Please specify _____

Are you under the care of a physician? ❑ Yes ❑ No For what conditions? _____

(Women) Do you suspect that you are pregnant? ❑ Yes ❑ No Are you nursing? ❑ Yes ❑ No

Is there anything else we should know about your medical history? _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ DATE _____
Signature (Parent if Minor)