Today's Date_____/_____/_____ Chart # ______________

Patient's Name ___________________________________

Patient's Medical/Dental History

Patient's current physical health is: Good / Fair / Poor Does the patient smoke or use tobacco in any other form? Y / N
Is the patient currently under the care of a physician? Y / N If yes, please explain: ____________________________________
Is the patient taking any prescription/over the counter drugs? Y / N If yes, please list: ____________________________________
Has the patient had any of the following:

Abnormal Bleeding/Hemophilia	Y / N	Diabetes	Y / N	Psychiatric Problems	Y / N
AIDS or HIV positive	Y / N	Epilepsy or Seizures	Y / N	Speech Problems	Y / N
Anemia	Y / N	Hepatitis	Y / N	Stroke	Y / N
Arthritis	Y / N	Herpes/Fever Blister	Y / N	Thyroid problems	Y / N
Artificial bones/joints/valves	Y / N	High/Low Blood Pressure	Y / N	Tuberculosis (TB)	Y / N
Asthma	Y / N	Kidney Problems	Y / N	Ulcer	Y / N

Please list any serious medical condition that the patient has ever had: ____________________________________
Has patient ever had injury to mouth/teeth/chin? Y / N If yes, describe ______________________________
Does the patient breath from his/her mouth while awake or sleep? Y / N
Any allergies to drugs or materials (latex, nickel, etc)? Y / N If yes, list ______________________________
Any history of heart problems (congenital defect, infection, or valve replacement)? Y / N If yes, describe ______________________________
If yes, physician's name and number ____
Has patient ever experience jaw pain (TMD or TMJ)? Y / N If yes, describe ______________________________
Have patient had or been evaluated for orthodontics? Y / N If yes, when? ______________ Where? ______________
Does the patient want anything changed about their smile? Y / N If yes, what would you change? ______________________
FEMALES: Is the patient pregnant? Y / N If yes, due date ________________

Parent/Guardian/Guarantor Financial & Insurance Information

His/Her Name: ____________________________________ Birthdate:____/____/____ Relationship:______________________
Address if different from patient: ____________________________ City:____________________ State:_________ Zip:____________
Cell #: (______)_________________ Home #: (______)______________________ Email:__________________________________
Dental Insurance:________________________ Subscriber's Name:___________________________ Subscriber's DOB:____/____/_____
Insurance ID or SS #: _______________________ Group #: _________________________
Dental Insurance 2:________________________ Subscriber's Name:___________________________ Subscriber's DOB:____/____/_____
Insurance ID #: _______________________ Group #: _________________________

Signature on File for Release of Information, assignement of benefits, and guarantee of payment

I authorize Thomas F. Braun, D.M.D., LLC, to release medical and/or dental information or any information pertaining to examination, treatment, history and medical or dental expenses to my insurance company(ies) for the purpose of processing insurance claims. This release may include the reviewing and/or copying of pertinent documents x-rays, or other clinical information for purposes of payment by my insurance company. I authorize payment of medical or dental insurace benefits to be made directly to Thomas F. Braun, D.M.D., LLC. I permit a copy of this authorization to be used in place of original. I further agree to accept full responsibility for payment of charges rendered to the above patient which are not paid by an insurance company.

Signature:______________________________________ Print Name:______________________________________ Date: _____/_____/______

If guarantor, relationship to the patient: __________________________________

Doctor's Signature: ____ Date: ______/______/________