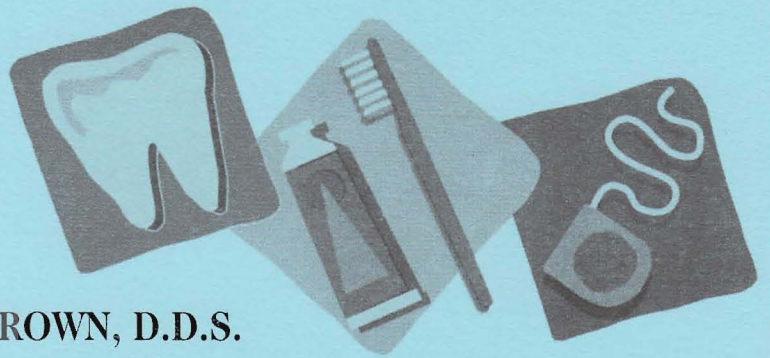


# WELCOME TO OUR PRACTICE!



**KERRY J. BROWN, D.D.S.**

2025 W. Long Lake Rd. Suite 110 Troy, MI 48098 Phone (248) 641-9490

## REGISTRATION

Date \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Business Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

Employed By \_\_\_\_\_

Single \_\_\_\_\_  
Married \_\_\_\_\_  
Divorced \_\_\_\_\_  
Widowed \_\_\_\_\_  
Separated \_\_\_\_\_

Whom may we thank for referring you \_\_\_\_\_

## PRIMARY DENTAL INSURANCE

Person Responsible for Account \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Responsible Party Employed By \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Address \_\_\_\_\_ Occupation \_\_\_\_\_

Insurance Company \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Subscriber I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

## SECONDARY DENTAL INSURANCE

Insured Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insured Employed By \_\_\_\_\_ Business Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Subscriber I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

Please complete reverse side

## DENTAL HISTORY

Former Dentist \_\_\_\_\_  
 City, State \_\_\_\_\_  
 Date of Last Dental Visit \_\_\_\_\_

Date of Last X-Rays \_\_\_\_\_  
 How Often Do You Floss? \_\_\_\_\_  
 How Often Do You Brush? \_\_\_\_\_

Please check all that apply:

- |                                                         |                                                           |                                                                  |
|---------------------------------------------------------|-----------------------------------------------------------|------------------------------------------------------------------|
| Bad Breath..... <input type="checkbox"/>                | Loose Teeth or Broken Fillings . <input type="checkbox"/> | Sensitivity to Sweets ..... <input type="checkbox"/>             |
| Bleeding Gums..... <input type="checkbox"/>             | Orthodontic Treatment ..... <input type="checkbox"/>      | Sensitivity When Biting ..... <input type="checkbox"/>           |
| Blisters on Lips or Mouth..... <input type="checkbox"/> | Pain Around Ear ..... <input type="checkbox"/>            | Frequent Headaches ..... <input type="checkbox"/>                |
| Fingernail Biting..... <input type="checkbox"/>         | Periodontal Treatment ..... <input type="checkbox"/>      | Jaw, Head or Neck Injuries..... <input type="checkbox"/>         |
| Grinding Teeth..... <input type="checkbox"/>            | Sensitivity to Cold..... <input type="checkbox"/>         | Jaw Difficulty: Clicking and/or Pain .. <input type="checkbox"/> |
| Lip or Cheek Biting ..... <input type="checkbox"/>      | Sensitivity to Heat..... <input type="checkbox"/>         | Tooth Pain ..... <input type="checkbox"/>                        |

## MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

- |                                                              |                          |                          |                                               |
|--------------------------------------------------------------|--------------------------|--------------------------|-----------------------------------------------|
|                                                              | Yes                      | No                       | 7. Please list any allergies to food or drugs |
| 1. Are you currently under medical treatment? ..             | <input type="checkbox"/> | <input type="checkbox"/> | _____                                         |
| 2. Have you ever had any serious illnesses or operations? .. | <input type="checkbox"/> | <input type="checkbox"/> | _____                                         |
| 3. Are you currently taking any medication? ..               | <input type="checkbox"/> | <input type="checkbox"/> | _____                                         |

Please describe: \_\_\_\_\_

- |                                                   |                          |                          |
|---------------------------------------------------|--------------------------|--------------------------|
| 4. Do you smoke? ..                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use alcohol, cocaine or other drugs? .. | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you wear contact lenses? ..                 | <input type="checkbox"/> | <input type="checkbox"/> |

- |                                |                          |                          |
|--------------------------------|--------------------------|--------------------------|
| 8. (Women Only) Are You:       | Yes                      | No                       |
| Pregnant?.....                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Nursing? ..                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Taking birth control pills? .. | <input type="checkbox"/> | <input type="checkbox"/> |

Please check all that apply:

- |                                                         |                                                     |                                                            |
|---------------------------------------------------------|-----------------------------------------------------|------------------------------------------------------------|
| AIDS..... <input type="checkbox"/>                      | Emphysema..... <input type="checkbox"/>             | Pacemaker..... <input type="checkbox"/>                    |
| Anemia..... <input type="checkbox"/>                    | Epilepsy..... <input type="checkbox"/>              | Psychiatric Care ..... <input type="checkbox"/>            |
| Arthritis, Rheumatism ..... <input type="checkbox"/>    | Fainting or Dizziness..... <input type="checkbox"/> | Radiation Treatment ..... <input type="checkbox"/>         |
| Artificial Heart Valves..... <input type="checkbox"/>   | Glaucoma..... <input type="checkbox"/>              | Respiratory Disease..... <input type="checkbox"/>          |
| Artificial Joints ..... <input type="checkbox"/>        | Headaches..... <input type="checkbox"/>             | Rheumatic Fever..... <input type="checkbox"/>              |
| Asthma..... <input type="checkbox"/>                    | Heart Murmur ..... <input type="checkbox"/>         | Scarlet Fever ..... <input type="checkbox"/>               |
| Back Problems ..... <input type="checkbox"/>            | Heart Problems ..... <input type="checkbox"/>       | Shortness of Breath ..... <input type="checkbox"/>         |
| Bleeding abnormally, with extractions or surgery .....  | Hepatitis - Type _____ .....                        | Sinus Trouble ..... <input type="checkbox"/>               |
| Blood Disease..... <input type="checkbox"/>             | Herpes..... <input type="checkbox"/>                | Skin Rash..... <input type="checkbox"/>                    |
| Cancer..... <input type="checkbox"/>                    | High Blood Pressure..... <input type="checkbox"/>   | Stroke ..... <input type="checkbox"/>                      |
| Chemical Dependency ..... <input type="checkbox"/>      | HIV Positive..... <input type="checkbox"/>          | Swelling of Feet/Ankles..... <input type="checkbox"/>      |
| Chemotherapy..... <input type="checkbox"/>              | Jaundice..... <input type="checkbox"/>              | Swollen Neck Glands..... <input type="checkbox"/>          |
| Chronic Fatigue Syndrome ..... <input type="checkbox"/> | Jaw Pain ..... <input type="checkbox"/>             | Thyroid Problems..... <input type="checkbox"/>             |
| Circulatory Problems ..... <input type="checkbox"/>     | Latex Sensitivity..... <input type="checkbox"/>     | Tonsillitis ..... <input type="checkbox"/>                 |
| Congenital Heart Lesions..... <input type="checkbox"/>  | Kidney Disease ..... <input type="checkbox"/>       | Tuberculosis..... <input type="checkbox"/>                 |
| Cortisone Treatments..... <input type="checkbox"/>      | Liver Disease ..... <input type="checkbox"/>        | Tumor or growth on head/neck..... <input type="checkbox"/> |
| Cough - persistent or bloody .....                      | Low Blood Pressure..... <input type="checkbox"/>    | Ulcer ..... <input type="checkbox"/>                       |
| Diabetes ..... <input type="checkbox"/>                 | Mitral Valve Prolapse..... <input type="checkbox"/> | Venereal Disease..... <input type="checkbox"/>             |
|                                                         | Nervous Problems ..... <input type="checkbox"/>     |                                                            |

I understand that even though I have some type of dental insurance coverage, I am responsible for payment of services not collectible from my company.

\_\_\_\_\_  
 Signature of Patient

\_\_\_\_\_  
 Date