



Welcome to
Braden Dental Center...
Two Generations of
Professional Care.

ADULT REGISTRATION & HISTORY

*W*e at Braden Dental Center appreciate your confidence in us, and we pledge to provide you with the finest in dental care. Please fill out this form carefully and completely. The more accurate the information and better we know you, the better we can care for you. We think that's important!

A handwritten signature in black ink, appearing to read 'Mark T. Braden'.

Mark T. Braden, D.D.S.

A handwritten signature in black ink, appearing to read 'Ryan T. Braden'.

Ryan T. Braden, D.D.S.

**Braden Dental Center is committed to meeting or exceeding the standards of
infection control mandated by OSHA, the CDC and the ADA.**

ADULT REGISTRATION & HISTORY

ABOUT YOU

Name: _____
Last First Middle Initial

I like to be called: _____

Birthday: _____ Male Female
Month Day Year

Single Married Divorced Widowed

Social Security #: _____

Your Employer: _____

Employer Address: _____
Street / P.O. Box

City State Zip Code

Occupation: _____ How long held: _____

Special interests, sports or hobbies: _____

Who referred you to us today? _____

Your Home Address: _____
Street / P.O. Box

City State Zip Code

Mailing Address, if Different:

City State Zip Code

CONTACT INFORMATION

Home Phone: _____

Work Phone: _____ Ext. _____

Cell Phone: _____

E-Mail: _____

When is the best time to reach you? _____

Where? _____ Spouse's employer phone: _____

In an emergency, who could we contact?

Name: _____

Relationship: _____

Work Phone: _____ Home Phone: _____

DENTAL INSURANCE

Do you have dental insurance through your employer?

Yes No

If yes, please provide the following information:

Dental Insurance Co. #1: _____

Group #: _____ Ins. Co. Phone: _____

Member ID #: _____

Ins. Co. Address: _____
Street P.O. Box

City State Zip Code

Do you have any other Dental Insurance Coverage?

Yes No

This coverage is through: Spouse Parent

Other: _____

Their Name: _____

Their Employer's Name & Address: _____

Their Social Security #: _____

Their Birthdate: _____
Month Day Year

Dental Insurance Co. #2: _____

Group #: _____ Ins. Co. Phone: _____

Member ID #: _____

Ins. Co. Address: _____
City State Zip Code

RELEASE OF INFORMATION

I authorize the release of any dental information necessary to process my claims.

Signature Date

ASSIGNMENT OF BENEFITS

I authorize payment directly to Braden Dental Center of group insurance benefits otherwise payable to me.

Signature Date

MEDICAL HISTORY

Although the staff at Braden Dental Center primarily treats the area in and around your mouth, your mouth is a part of your entire body. Health problems you may have, or medications you may be taking, can have an important relationship with the dentistry you will receive. Thank you for answering the following medical questions.

Personal Physician's Name: _____

Address: _____

Phone: _____

Approximate date of your last doctor's visit: _____

Your current physical health is:

- Good Fair Poor

Are you currently under the care of any physician?

- Yes No. If yes, please explain: _____

Do you smoke or use tobacco in any other form?

- Yes No

Do you use any controlled substances?

- Yes No. If yes, describe: _____

Are you presently taking any drugs prescribed by a physician or dentist?

- Yes No. If yes, please list: _____

Are you on a special diet?

- Yes No

For women:

Are you taking oral contraceptives?

- Yes No

Are you pregnant/trying to get pregnant?

- Yes No

Are you nursing?

- Yes No

Do you need to be premedicated before dental treatment?

- Yes No

Have you had any serious medical problems in the last 5 years?

- Yes No. If yes, describe: _____

Have you ever been hospitalized or had a major operation?

- Yes No. If yes, describe: _____

Have you ever had a serious head or neck injury?

- Yes No. If yes, describe: _____

Have you ever had any of the following diseases, medical problems or treatments?

- | | |
|--|---|
| <input type="checkbox"/> AIDS/HIV+ | <input type="checkbox"/> Heart Surgery |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Heart Trouble/Disease |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Hepatitis B or C |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Hives/Rash |
| <input type="checkbox"/> Artificial Joint* | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Irregular Heartbeat |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Bruising Easily | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Mitral Valve Prolapse* |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Parathyroid Disease |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Radiation Treatments |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Renal Dialysis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic Fever* |
| <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Frequent/Severe Headaches | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Heart Murmur* | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Heart Pacemaker* | <input type="checkbox"/> Yellow Jaundice |

OFFICE USE ONLY

Doctor's Comments:

*Condition may require medication.

Have you ever had any serious illness or medical conditions not listed above?

- Yes No

If yes, describe: _____



Are you allergic to any of the following?

- Acrylic Aspirin Codeine Dental Anesthetics
 Erythromycin Latex Metal Penicillin
 Tetracycline Other

If other, please list: _____

DENTAL HISTORY

Why have you come to Braden Dental Center today?

Are you currently in pain?

- Yes No

Are you under any unusual stress at home or work?

- Yes No

Do you experience stress or anxiety when you visit a dental office?

- Yes No

Approximate date of your last dental visit: _____

Have you ever experienced TMJ problems (pain or discomfort in your jaw joints)?

- Yes No

Do you grind your teeth?

- Yes No

Your current dental health is:

- Good Fair Poor

Do your gums ever bleed?

- Yes No

Do you like your smile?

- Yes No

Are you interested in whitening your smile?

- Yes No

Any other comments or additional information you think we should know about you?

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform Braden Dental Center of any changes in my medical status.

Signature

Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Thank you for filling out this form carefully and completely. It will allow us to treat you more effectively and provide the latest and best in dental care. If you have any questions at any time, please don't hesitate to ask!



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