

# Midsouth Urgent Dental Care™ – Joseph J. Brown, D.M.D

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## Patient Information:

Name: \_\_\_\_\_ Birth Date \_\_\_\_\_

Street Address \_\_\_\_\_

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

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Cell Phone(\_\_\_\_\_) \_\_\_\_\_ Social Security No. \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

Circle Appropriate      Child      Single      Married      Other

Patient's or Parent's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

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

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

Spouse or Parent's Name \_\_\_\_\_ Work Phone \_\_\_\_\_

If Patient is a Student, Name of School/College \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Whom May We Thank for Referring You? \_\_\_\_\_

Person to Contact in Case of Emergency \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

## Responsible Party

Name of Person Responsible for this Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

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

Driver's License # \_\_\_\_\_ Birth Date \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Is this person a patient in this office?      Yes      No

## Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_

Name of Employer \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Union or Local No. \_\_\_\_\_

Do you have any additional insurance? If yes, complete the following:

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_

Name of Employer \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Union or Local No. \_\_\_\_\_

## Patient Medical History

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

Are you under medical treatment now?	Yes	No
Have you ever been hospitalized for any surgical operation of serious illness?	Yes	No
Are you taking any medications including non-prescription medicine? If yes, what medications are you taking? _____	Yes	No
Do you use tobacco?	Yes	No
Do you use alcohol, cocaine or other drugs?	Yes	No
Are you wearing contacts?	Yes	No
Have you ever had a head, neck or jaw injury?	Yes	No
<b>For Women Only:</b>		
Are you pregnant or think you may be pregnant?	Yes	No
Are you nursing?	Yes	No
Are you taking birth control?	Yes	No

### Are you allergic to or have you had any reactions to the following?

Local Anesthetics (e.g. Novocaine)	Yes	No
Aspirin	Yes	No
Codeine	Yes	No
Erythromycin	Yes	No
Latex	Yes	No
Penicillin or other Antibiotics	Yes	No
Sedatives	Yes	No
Sulfa Drugs	Yes	No

### Do you have any of the following?

Allergies	Yes	No	Fainting	Yes	No	Radiation Treatment	Yes	No
Anemia	Yes	No	Glaucoma	Yes	No	Respiratory Problem	Yes	No
Arthritis	Yes	No	Head Injuries	Yes	No	Rheumatic Fever	Yes	No
Artificial Joints or Implants	Yes	No	Heart Attack	Yes	No	Rheumatism	Yes	No
Asthma	Yes	No	Heart Disease	Yes	No	Sexually Transmitted Disease	Yes	No
Blood Disease	Yes	No	Heart Murmur	Yes	No	Sinus Problems	Yes	No
Blood Thinners	Yes	No	Hepatitis	Yes	No	Stomach Problem/Ulcers	Yes	No
Cancer	Yes	No	High Blood Pressure	Yes	No	Stroke	Yes	No
Cardiac Pacemaker	Yes	No	HIV/Aids Infection	Yes	No	Thyroid Problem	Yes	No
Chest Pains	Yes	No	Jaundice	Yes	No	Tuberculosis	Yes	No
Diabetes	Yes	No	Kidney Disease	Yes	No	Tumors	Yes	No
Dizziness	Yes	No	Leukemia	Yes	No	Other	Yes	No
Emphysema	Yes	No	Liver Disease	Yes	No			
Epilepsy/Convulsions	Yes	No	Low Blood Pressure	Yes	No			
Excessive Bleeding	Yes	No	Pacemaker					

### Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been answered accurately. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any treatment or examination rendered to me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X \_\_\_\_\_ Date: \_\_\_\_\_

(Signature of Patient or Parent if Minor)