HEIDI BRANDENBURG
DDS

3948 West 50th Street | Suite 201 | Edina, MN 55424 | 952 922 8787 | hb-dds.com

Patient Information / Adult

The following confidential information is important for the dentist to know planning your dental care. Please answer each question as completely as you can. Thank you.

Patient Name	Date of Birth	
Address	Cell Phone #	
City, State, Zip	Home Phone #	Preferred Contact Method
Email Address	Social Security #	
Employer	Position	Work Phone #
Name of person to contact in case of emergency	Phone #	
How did you find out about our dental office?		

Account Information

Person Responsible for Account (address and phone, if different from above)	Social Security #
If you will be using Dental Insurance, please provide the following:	
Dental Insurance Company	Group #
Subscriber Name	Subscriber Date of Birth
Subscriber Employer	Subscriber ID#

Health Information—Dental

Previous Dentist		**Do any of the following apply to you now or in the past?**					
Address		Toothache	Yes	No	Mouth sores	Yes	No
Last Dental Exam	Last Dental X-Rays	Cold sensitivity	Yes	No	Swelling in the mouth	Yes	No
Reason for this visit		Heat sensitivity	Yes	No	Unpleasant taste	Yes	No
What do you feel is the present condition of your mouth?		Pressure sensitivity	Yes	No	Food Collects	Yes	No
Are you interested in regular dental care?		Sweet sensitivity	Yes	No	Grinding/Clenching	Yes	No
How often do you brush your teeth?		Bleeding gums	Yes	No	Jaw joint noise	Yes	No
What type of toothbrush do you currently use? Manual? Electric?		Gums hurt	Yes	No	Locked jaw	Yes	No
How often do you floss your teeth?		Gum treatment	Yes	No	Improper bite	Yes	No
If you could change anything about your smile, what would it be?		Loose teeth	Yes	No	Braces	Yes	No
		Bad breath	Yes	No	Unattractive teeth	Yes	No
		Other? Please explain:					

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Health Information—Medical	Patient Name					
Physician's Name	Are you allergic to:					
Address	Penicillin	Yes	No	Local Anesthetic	Yes	No	Other Allergies:
Phone	Codeine	Yes	No	Latex	Yes	No	
Are you currently under the care of a physician? If yes, explain.	List all medications or drugs (and dosages) that you are taking:						
Have you ever had a serious illness or accident? If yes, explain.							
Women—are you pregnant? If yes, how long?							

Do any of the following apply to you now or in the past?

Heart Disease	Yes	No	Thyroid Problem	Yes	No	Tuberculosis/Lung Disease	Yes	No	Tumors	Yes	No
Rheumatic Fever	Yes	No	Jaundice	Yes	No	Asthma/ Hay Fever	Yes	No	Radiation Therapy	Yes	No
Heart Murmur	Yes	No	Hepatitis	Yes	No	Sinus Problems	Yes	No	Osteopenia/ Osteoporosis	Yes	No
Congenital Heart Defect	Yes	No	Ulcers/ Reflux	Yes	No	Epilepsy/ Seizures	Yes	No	Prosthetic Joint/ Implant	Yes	No
Abnormal Blood Pressure	Yes	No	Diabetes	Yes	No	Fainting Spells	Yes	No	HIV/AIDS	Yes	No
Abnormal Bleeding	Yes	No	Excessive Thirst/ Urination	Yes	No	Chemical Dependency	Yes	No	HPV	Yes	No
Stroke	Yes	No	Anemia	Yes	No	Mental Health Care	Yes	No	Tobacco User	Yes	No

Any additional information? Please explain:

The information is correct to the best of my knowledge. I authorize the performance of diagnostic and therapeutic procedures, and the administration of such medications as may be necessary for proper dental care.

Patient Signature	Date
D.D.S. Signature	Date