DR. BRYAN N. KOOPMANN 3901 South Lamar, #400 Austin, Texas 78704 442-7897

Personal Information and Medical History

Cell #____________________(optional) EMAIL____________________

Patient's Name ____________________ Date of Birth ____/____/____ Sex M / F____ Marital Status: S-M-D-W ________ Date: ____________

Address ____________________ City ____________ St. ____________ Zip ____________ Referred by ____________________

Home Ph.# (____)____________________ Bus. Ph. # (____)____________________ Ext. ______ SS# ______-______-______

Occupation ____________________ Employer ____________________ Bus. Address ____________________ City ________ St. ______ Zip ______

SPOUSE - PLEASE COMPLETE INFORMATION: Name ____________________ Date of Birth ____/____/____ SS# ______-______-______

Employer ____________________ Bus. Address ____________________ City ____________ St. ________ Zip ____________

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT: Name ____________________ Relationship to Patient ____________

Address ____________________ City ____________________ St. ____________ Zip ____________________

Home Ph. # (____)____________ Bus Ph. # (____)____________ Ext. ______ Date of Birth ____/____/____ SS# ______-______-______

Occupation ____________________ Employer ____________________ Bus. Address ____________________ City ____________ St. ______ Zip ______

PRIMARY DENTAL INSURANCE: Dental Insurance Co. ____________________ Policy Holder ____________________

Group No. ____________________ Date of Birth ______/______/______ SS# ______-______-______

SECONDARY DENTAL INSURANCE: Dental Insurance Co. ____________________ Policy Holder ____________________

Group No. ____________________ Date of Birth ______/______/______ SS# ______-______-______

In case of an emergency (Please list relative not living with you) Name ____________________ Phone No. ____________

Address ____________________ City____________________ St. ____________ Zip ____________

Your answers to the following questions are for our records only and will be considered confidential. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure .... YES NO	Rheumatism .... YES NO	Tuberculosis .... YES NO	Blood Transfusion .... YES NO
Heart Disease or Attack .... YES NO	Cortisone Medicine .... YES NO	Asthma .... YES NO	Hemophilia .... YES NO
Angina Pectoris .... YES NO	Drug Addiction .... YES NO	Hay Fever .... YES NO	Anemia .... YES NO
Congenital Heart Disease .... YES NO	Stroke .... YES NO	Allergies or Hives .... YES NO	Sickle Cell Disease .... YES NO
Heart Murmur .... YES NO	Artificial Joints (hip, knee, etc.) .... YES NO	Sinus Trouble .... YES NO	Bruise Easily .... YES NO
High Blood Pressure, High-Low .... YES NO	Kidney Trouble .... YES NO	Radiation Therapy .... YES NO	Liver Disease .... YES NO
Arteriosclerosis .... YES NO	Ulcers .... YES NO	Chemotherapy .... YES NO	Yellow Jaundice .... YES NO
Mitral Valve Prolapse .... YES NO	Diabetes .... YES NO	Hepatitis A (infectious) .... YES NO	Epilepsy or Seizures .... YES NO
Artificial Heart Valve .... YES NO	Thyroid Problems .... YES NO	Hepatitis B (serum) .... YES NO	Fainting or Dizzy Spells .... YES NO
Heart Pacemaker .... YES NO	Glaucoma .... YES NO	Venereal Disease .... YES NO	Nervousness .... YES NO
Heart Surgery .... YES NO	Cosmetic Surgery .... YES NO	A.I.D.S. .... YES NO	Psychiatric Treatment .... YES NO
Rheumatic Fever .... YES NO	Emphysema .... YES NO	H.I.V. Positive .... YES NO	Developmentally Disabled .... YES NO
Arthritis .... YES NO	Chronic Cough .... YES NO	Cold Sores/Fever Blisters .... YES NO	Cancer of Any Nature .... YES NO

Name of Physician ____________________ Phone #(____)____________ Are you under the care of a Physician? yes ☐ no ☐

List any and all medications or drugs you are now taking: ____________________

____________________ HEIGHT____________ WEIGHT____________

Are you allergic or have you reacted adversely to:

- Local anesthetics or dental injections? .... YES ☐ NO ☐
- Codeine or other narcotics .... YES ☐ NO ☐
- Penicillin or other antibiotics .... YES ☐ NO ☐
- Aspirin? .... YES ☐ NO ☐
- Any metal or jewelry .... YES ☐ NO ☐
- List any other allergy or medical alerts you may have: ____________________

Have you had any problems associated with any previous dental treatment .... YES ☐ NO ☐

If so, explain ____________________

What is your main dental concern? ____________________

When was your last dental visit? ____________________

Do you have any disease, condition, or problem NOT listed above that we should know about? ____________________

WOMEN

1. Are you pregnant? (list month) .... YES ☐ NO ☐ 2. Any complications to date? .... YES ☐ NO ☐ 3. Are you nursing? .... YES ☐ NO ☐

I/we authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with named patient above. Also, I/we understand that all responsibility for payment for all dental services provided in this office for myself or my dependents is mine, due and payable at the time of services are rendered unless other arrangments have been made. I/we hereby authorize release of any information relating to dental treatment and dental claims. In the event payments are not received by the agreed upon dates, I understand that a 1.25% finance charge (15% A.P.R.) will be added to my account.

Patient Signature ____________________ Date ____________________

Parent or Responsible Party ____________________ Relationship to Patient ____________________

DENTAL HISTORY AND COMPREHENSIVE EXAM

PLEASE COMPLETE

Date of Last Dental Cleaning?____________ Receive Care Regularly? Yes/No Last X-Rays?______________
Discomfort Now? Yes/No Any Missing Teeth? Yes/No Cause?_________________________
Replacement Discussed? Yes/No
Missing Teeth Replaced By: (Circle One) Fixed Bridge Partial Implant Denture
Food Collecting Between Teeth? Yes/No Location? Upper-Right/Left Lower-Right/Left
Sensitive to: Hot? Yes/No Cold? Yes/No Sweets? Yes/No Unpleasant Taste? Yes/No
Do You Floss? Yes/No When?______________ Water Jet? Yes/No Other?__________________
How Often Do You Brush Your Teeth?______/day When?_________ Gums Bleed? Yes/No When?____________
How Do You Feel About Your Teeth In General?____
How Do You Feel About Their Appearance?____
How Do You Feel About Your Smile?____
TMJ/MUSCLE
Headaches? Yes/No Facial Pain? Yes/No Pain in Region of Ear? Right/Left/No Popping, Clicking or Grating of the Joints? Yes/No Grinding or Clenching? Yes/No Day?_____ Night?_____
Chew on One Side of Mouth? Right/Left Why?____

TMJ EVALUATION

1. Joints: Smooth, Popping, Grating, Full Mobility, Ltd. Mobility
2. Temporalis Muscles
   Anterior Attachments: (R) (L)
   Distal Attachments: (R) (L)
3. Pterygoid Muscles: (R) (L)
   Pterygomandibular Ligaments: (R) (L)
4. Buccinator Muscles: (R) (L)
5. Submandibular Lymph Glands: (R) (L)
6. Parotid Glands: (R) (L)

SOFT TISSUES
General Conditions: Good Fair Poor Lips _______ Buccal Mucosa _________
Attachments _______ Palate _______ Floor of Mouth _______ Tongue _______
Oral Lesions _______ Ulcers _______ Tumors ________ Tori ________

PERIODONTAL EVALUATION CLASS I II III IV V
Gingivitis__________ Periodontitis__________ Anug________Abscesses/Fistulas__________
Apical_________ Marginal Gingivae________ Papillae________ Bleeding________ Exudate________
Any Bone Loss________ Calculus: Slight Moderate Heavy Subgingival

OCCLUSION CLASS I II III OVERJET OVERBITE INTERFERENCES:
Centric ____
Balancing ____
Protrusive____
Working____
Incisal Guidance______, Opening: ___mm, Traumatized Teeth_________
Heavy Wear__________, Loose Contacts______, Eroded______, Overhanging Margins_____, Fractured______,
Percussion Sens. ______, Mobility I_______, II_______, III_______,IV_______