DR. REBECCA H. HOWELL
Family and Cosmetic Dentistry
606 Davis Circle SW
Huntsville, AL 35801

Telephone: (256) 533-1131

WELCOME!

We would like to welcome you to our practice. We are honored by your call for an appointment and we are looking forward to meeting you. Most of our clients come by referral. When one recommends us to a friend, we consider it a great compliment.

Your initial visit is a clinical examination to determine your dental needs. Diagnostic records such as x-rays, study models, or photographs may be taken to aid Dr. Rebecca Howell in determining if any restorative treatment is needed. A professional cleaning by our hygienist may begin at this appointment. If you have not been under the care of a dentist for a long time, multiple visits may be necessary for us to provide you with a healthy smiling mouth. We will do everything we can to make your visit(s) pleasant.

We respect your time when you visit us. We have enclosed a patient information/medical history form. By filling out the enclosed form and bringing it with you, you can help us make your visit to our office as efficient as possible.

To help you locate our office, on the back of this letter is a map marked with our location of 606 Davis Circle. Our office is conveniently located near the downtown Public Library and the Holiday Inn Select Hotel (formerly the Hilton) near the Parkway and Governors intersection. From St. Clair Street in front of the library, turn north onto Pelham, then left onto Davis Circle. The office is at the end of the circle on your right.

We ask that all new patients joining the practice take care of the charges in full at the initial appointment. We are happy to provide a written estimate prior to any needed treatment being performed, please don't hesitate to ask our administrative staff. Also, we kindly assist you with filing *ALL* of your insurance claims and we are a *Delta Dental Premiere Provider*. Please bring your insurance card and benefits information.

We are pleased you chose us. Should you need us before your appointed date please call us at **256-533-1131**. We look forward to taking care of your dental needs. See you soon.

Thank you,

Dr. Rebecca H. Howell and Staff

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address:	Today's Date:	Date of Last Visit:	Date of Med. History:

City State Zip:	Email:

Home Phone:	Work Phone:	Cell Phone:	Birth Date:	Social Security No.:	Marital Status:

Primary Dental Guarantor:	Home Phone:	Work Phone:	Cell Phone:

Secondary Dental Guarantor:	Home Phone:	Work Phone:	Cell Phone:

Physician Name:	Physician Phone:

Pharmacy:	Pharmacy Phone:

For Office Use Only

Medical Alerts:

Sex:

If female please answer the following:

Y N
- ☐ ☐ Are you taking Birth Control Pills?
- ☐ ☐ Are you pregnant? If Yes, # of weeks ☐
- ☐ ☐ Are you nursing?

Please answer the following:

Y N
- ☐ ☐ Do you smoke or use tobacco?

For Office Use Only
BP ☐ Heart Rate: ☐

Height: ☐

Weight: ☐

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Bones
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer- Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Y	N	Conditions
☐	☐	Glaucoma
☐	☐	Hay Fever
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	High Blood Pressure
☐	☐	HIV+ AIDS
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Pneumocystitis
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems

Y	N	Conditions
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Yellow Jaundice

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)