Family and Cosmetic Dentistry
DentistryDowntown.com

Dentistry Downtown
Dr. Rebecca H. Howell

606 Davis Circle SW
Huntsville, AL 35801

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 one of our hygienists 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.

Our office is conveniently located near the downtown Public Library and the new AC Hotel by Marriott near the Parkway ad Governors intersection. From Governors, turn north onto Monroe St, then at the traffic circle, take the 1st right onto Davis Circle. The office is on the left.

We ask that all new patients joining our practice take care of the charges in full at the initial appointment. We are happy to provide a written estimate prior to any needed dental 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 awe 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:	Today's Date:

Address:	City / State / Zip:

E-mail:	Birthdate:	Social Security No.:	Marital Status:

Home Phone:	Work Phone:	Cell Phone:	Emergency Contact and Cell #:

Name of Person Responsible for this Account:	Relationship to Patient:	Birthdate:	Social Security No.:

Address:	City / State / Zip:

Employer:	Work Phone #:	Cell Phone:	Driver's License #:

PRIMARY Name of Insured:	Relation to Patient:	Birthdate:	Social Security No.:

Employer:	Work Phone:	Insurance Company:	Group #:

SECONDARY Name of Insured:	Relation to Patient:	Birthdate:	Social Security No.:

Employer:	Work Phone:	Insurance Company:	Group #:

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?

Height: ☐

For Office Use Only
BP ☐ Heart Rate: ☐

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

Y	N	Conditions
❑	❑	Frequent Headaches
❑	❑	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

Y	N	Conditions
❑	❑	Sickle Cell Disease
❑	❑	Sinus Problems
❑	❑	Stroke
❑	❑	Thyroid Problems
❑	❑	Tuberculosis
❑	❑	Ulcers
❑	❑	Venereal DIsease
❑	❑	Yellow Jaundice

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

Other ______________________

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Physician Name:	Physician Phone:	Pharmacy:	Pharmacy Phone:

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:

Y N

☐ ☐ Have you had any serious illnesses or operations?
If yes, please describe below:

Signature: ______________________________ Date: ______________
(If Under 18, Parent or Guardian Signature Required)