DENTAL REGISTRATION AND HEALTH HISTORY

PATIENT INFORMATION

Date:_____

Soc. Security #/Patient ID #:_____

Patient Name:_____
Last First Middle Initial

Gender:_____ Date of Birth:_____ Age:_____ E-mail:_____

Phone (Home):_____ (Work):_____ Ext:_____ (Cell):_____

Address:_____City:_____State:_____Zip:_____

☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Minor ☐ Partnered

Employer/School:_____Occupation:_____

Whom may we thank for referring you? ☐ Patient ☐ Friend/Relative ☐ Dental Office ☐ Yellow Pages ☐ Other

Name of person or office referring you to our practice:_____

DENTAL INSURANCE INFORMATION

Primary Subscriber:

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:_____

Name of Insured:_____
Last First Middle Initial

Insured Soc. Security #/Id #:_____Insured's Birth Date:_____

Insured's Address:_____

Insured's Phone (Home):_____ (Work):_____ Ext:_____ (Cell):_____

Insured's Employer Name:_____

Insurance Plan Name:_____ Group #:_____

Secondary Subscriber:

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:_____

Name of Insured:_____
Last First Middle Initial

Insured Soc. Security #/Id #:_____Insured's Birth Date:_____

Insured's Address:_____

Insured's Employer Name:_____

Address:_____

Insurance Plan Name:_____ Group #:_____

Emergency Contact:_____

Relation:_____ Phone #:_____

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. I understand that I am responsible for payment of services rendered and for paying any deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits.

Signature:_____ **Date:**_____

PAYMENT IS DUE AT TIME OF SERVICE

DENTAL HISTORY

Patient Name:_____ Date:_____
Reason for today's visit:_____ Date of last dental visit:_____
Former Dentist:_____ City/State:_____

Check "YES" or "NO" to indicate if you have chronically had any of the following:

Bad breath	☐ Yes ☐ No	Lip or cheek biting	☐ Yes ☐ No	Sensitivity to hot/cold	☐ Yes ☐ No
Bleeding gums	☐ Yes ☐ No	Loose teeth/broken fillings	☐ Yes ☐ No	Sensitivity to sweets	☐ Yes ☐ No
Blisters on lips or mouth	☐ Yes ☐ No	Mouth breathing	☐ Yes ☐ No	Sensitivity when biting	☐ Yes ☐ No
Burning sensation on tongue	☐ Yes ☐ No	Mouth pain, brushing	☐ Yes ☐ No	Sores or growths in mouth	☐ Yes ☐ No
Chew on one side of mouth	☐ Yes ☐ No	Orthodontic treatment	☐ Yes ☐ No	Gums swollen/tender	☐ Yes ☐ No
Cigarette/pipe/cigar smoking	☐ Yes ☐ No	Pain around ear	☐ Yes ☐ No	Food collection	☐ Yes ☐ No
Clicking/popping jaw	☐ Yes ☐ No	Periodontal treatment	☐ Yes ☐ No	Smokeless tobacco	☐ Yes ☐ No
Dry Mouth	☐ Yes ☐ No	Fingernail biting	☐ Yes ☐ No	How often do you brush?	_____
Grinding teeth	☐ Yes ☐ No	Jaw pain or tiredness	☐ Yes ☐ No	How often do you floss?	_____

Answer the following questions regarding your dental experiences in order for us to serve you better:

Have you had excessive anxiety with dental procedures? ☐ Yes ☐ No
Do you require anti-anxiety medications with procedures? ☐ Yes ☐ No
Do you have a difficult time getting numb? ☐ Yes ☐ No

How can we improve your dental experience?

☐ Headphones/music ☐ Back and/or neck support
☐ Mouth prop during procedures ☐ Topical numbing for cleaning procedures
Are you interested in teeth whitening or cosmetic procedures? ☐ Yes ☐ No

HEALTH HISTORY

Physician's Name:_____ Date of last visit:_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fasting (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Are you or have you ever taken medications such as Prolia or Fosamax for osteoporosis, if so what? ☐ Yes ☐ No _____

Check "YES" or "NO" to indicate if you have/had any of the following:

AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Anemia	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Artificial Joints	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Asthma	☐Yes ☐ No	Heart Problems	☐ Yes ☐ No	Headaches	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Artificial Heart Valves	☐ Yes ☐ No	Tumor or growth head/neck	☐ Yes ☐ No
Respiratory Disease	☐ Yes ☐ No	Circulatory Problems	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Shortness of breath	☐ Yes ☐ No	Congenital Heart Lesions	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No
Kidney Disease	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Liver Disease	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Chemical Dependency	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Radiation Treatment	☐ Yes ☐ No	Hepatitis Type_____	☐ Yes ☐ No	Cortisone Treatments	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
		Herpes	☐ Yes ☐ No	Gastric Bypass	☐ Yes ☐ No
Jaundice	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Other:_____	

Functional Heart Murmur, Artificial Joints or Artificial Heart Valves that requires antibiotics: ☐ Yes ☐ No

Women: Are you taking birth control pills? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Medications:

Medications you are currently taking and the correlating diagnosis:

_____
_____
_____

Pharmacy Name & Location:_____

Are you allergic to any of the following?

☐ None ☐ Amoxicillin ☐ Penicillin
☐ Aspirin ☐ Erythromycin ☐ Sedatives
☐ Barbiturates ☐ Jewelry/Metals ☐ Sulfa Drugs
☐ Codeine ☐ Latex ☐ Tetracycline
☐ Anesthetics ☐ Other
☐ Please list additional allergies:_____

We require 48 hours' notice if you're unable to keep your appointment otherwise a charge will be made.

HIPAA CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Patient Name: _____

Patient Signature: _____ Date: _____

Please list any persons you wish to have access to your account:
(All areas of account will be accessible, unless documented below)

Name: _____ Relation: _____
Name: _____ Relation: _____
Name: _____ Relation: _____

_____
_____
_____

David C. Brown, DDS, Inc.

SMILE EVALUATION

Name: _____ *Date:* _____

1. Do you like the way your teeth look? Yes No
   Explain: _____
2. Are you happy with the color of your teeth? Yes No
   Explain: _____
3. Would you like for your teeth to be whiter? Yes No
4. Would you like for your teeth to be straighter? Yes No
   what areas? _____
5. Do you have spaces between your teeth that you would like closed? Yes No
   what areas? _____
6. Would you like your teeth to be longer? Yes No
   Explain: _____
7. Do you like the shape of your teeth? Yes No
   Explain: _____
8. Do you have missing teeth that you would like to replace? Yes No
   Explain: _____
9. Do you have old silver fillings that you would like to replace with tooth-colored fillings? Yes No
   Explain: _____
10. If you could change anything about your smile, what would you change?
    Explain: _____
    _____

OFFICE POLICIES

MISSED APPOINTMENT POLICY

We strive to keep a schedule that allows us to provide treatment within a set amount of time. This time is reserved especially for you, thus it is imperative that patients show up to their appointments on time. We stress and uphold a 48–hour cancellation policy. There is a $50 missed appointment fee. Please realize we need sufficient notice if you are canceling an appointment, as it is impossible to fill your appointment time at such late notice. We ask that you carefully write down the date and time of your appointments. If you would like us to confirm your appointments you will need to provide us with an email address and/or cell phone number. As a courtesy, we will then send you an appointment reminder via email and/or text 2 days before your appointment. However, it is your responsibility to make and keep all appointments.

FINANCIAL POLICIES

If you do not have insurance that we will be billing, payment for services is due at time of service, and is the patient's responsibility. We are more than happy to bill or authorize your dental insurance carrier for treatment. We accept cash, check, American Express, Discover, MasterCard or Visa. For patients interested in payment plans, please inquire about CareCredit®, a financial service we offer.

DENTAL INSURANCE

As a courtesy we will bill your insurance and do our best to help you with benefit information. However it is the patients' responsibility to know their individual benefits. With the continuing changes in policies it is impossible for us to be informed as to everyone's benefits. Like most dental benefit plans the patient should refer to his/her plan booklet, your employer's Human Resources department or your insurance agent to verify your provider and complete plan details, exclusions and limitations. It is also suggested that we preauthorize any treatment if you are unsure of your insurance benefits. We cannot be held responsible for information that cannot be attained due to identity safety and HIPAA consideration/requirements. Please remember that your dental insurance is a discount plan and that there will be times where your dental health requires treatment that may not be covered by your insurance.

Thank you so much for helping us to maintain an environment that not only allows us to sustain a professional atmosphere but also helps us to serve you and your family in the best way possible.

Patient Print Name:_____

Patient Signature:_____ **Date:**_____

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DENTAL MATERIAL FACT SHEET

I _____, acknowledge I can request a copy of the Dental Materials Fact Sheet dated May 2004, as required by law from Dr. Brown's dental office.

Patient Signature:_____ **Date:**_____