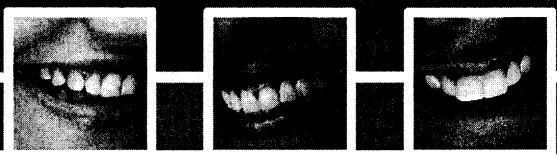
BROOKS COSMETIC & FAMILY DENTISTRY
70 WESTRIDGE PARKWAY
SUITE 200
MCDONOUGH, GA 30253
(678)583-0330
info@brooks-dentistry.com
www.brooks-dentistry.com



Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____
_____ (City) _____ (State) _____ (Zip Code)

How would you prefer to be contacted?

* ☐ Phone Call ☐ Text Message ☐ Email ☐ Post Card

Whom may we thank for referring you to our practice?

☐ Dental Office ☐ Yellow Pages
☐ Internet ☐ Newspaper
☐ School ☐ Work
☐ Another Patient (Name Below) ☐ Other (Name Below)

Name of person, office, or other source referring you to our practice:

_____

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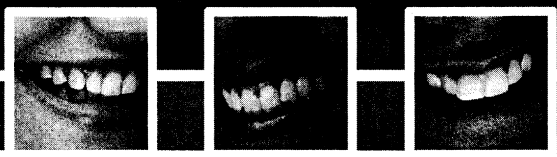

Spouse or Responsible Party Information

The following is for: * ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name:* _____ * _____ _____ _____
Last First MI Preferred Name

Title: _____ Gender:* ◯ Male ◯ Female Family Status:* ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date:* _____ Email Address: _____

Phone:* _____ _____ _____ _____ Best time to call: _____
Home Work Ext Mobile

Address:* _____ _____
* _____ * _____ * _____
City State Zip Code

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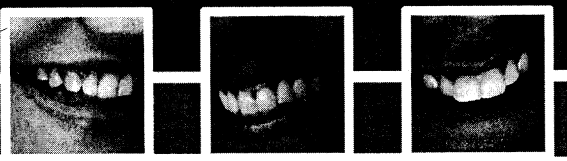

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____ _____

_____ _____ _____

City State Zip Code

Primary Dental Insurance:

Name of Insured: _____ _____ _____

Last First MI

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ _____ _____

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____

_____ _____ _____

City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ _____ _____

City State Zip Code

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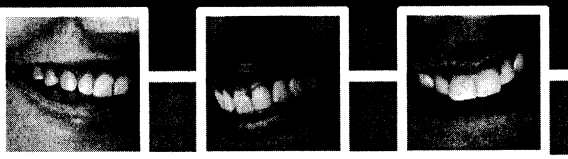

*Secondary Dental Insurance: (If Applicable)

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

*We will collect co-payments based on primary dental insurance only and file your secondary insurance as a reimbursement to you.

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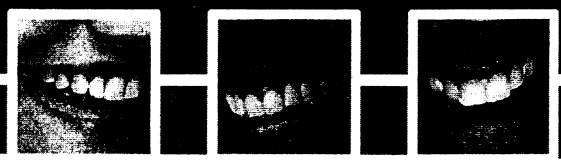

AUTHORIZATION

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature: _____ Date: _____

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CONSENT FOR SERVICES

Please Give Us 48 Hours Notice If You Cannot Keep An Appointment. A Charge Will Be Incurred For Missed Appointments.

I have completed the health questionaire to the best of my knowledge. I declare all answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended..

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

Signature of patient, parent, or guardian: _____ Date: _____

Signature: _____

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HIPAA

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g., my insurance company);

I have also been informed of, and given the right to review and secure a copy of your Notices of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signature of patient, parent, or guardian:

Signature: _____ Date: _____

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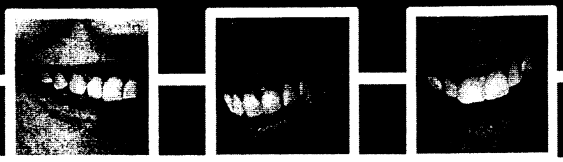

Medical & Dental History Form

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

☐ Alcohol/Drug Abuse	☐ Allergies/Hay Fever	☐ Allergy- Amoxicillin	☐ Allergy- Iodine
☐ Allergy- Metal	☐ Allergy- Other Meds	☐ Allergy- Penicillin	☐ Allergy-Aspirin
☐ Allergy-Codeine	☐ Allergy-Latex	☐ Allergy-Local Anesth	☐ Allergy-Sulfa
☐ Anemia	☐ Arthritis	☐ Artificial Joints	☐ Asthma
☐ Blood Disease	☐ Blood Thinners	☐ Cancer	☐ Cold Sores
☐ Diabetes	☐ Dizziness/Fainting	☐ Epilepsy/Seizures	☐ Excessive Bleeding
☐ Glaucoma	☐ Growths/Tumors	☐ Head Injuries	☐ Heart Attack/Failure
☐ Heart Disease	☐ Heart Murmur	☐ Heart Pacemaker	☐ Hepatitis
☐ High Blood Pressure	☐ HIV	☐ Jaundice	☐ Kidney Disease
☐ Liver Disease	☐ Mental Disorders	☐ Mitral ValveProlapse	☐ Nervous Disorders
☐ Osteoporosis	☐ Other	☐ Pre Medicate	☐ Pregnancy
☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism
☐ Sinus Problems	☐ Stomach Problems	☐ Stroke	☐ Thyroid Disease
☐ Tobacco Use	☐ Tuberculosis	☐ Ulcers	☐ Venereal Disease

Do you have any other health issues or allergies that are not listed above?

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Have you or are you currently taking medications for bone density/osteoporosis such as Fosamax,Boniva, or any meds. containing bisphosphonates?

◯ Yes ◯ No

Please list all medications you are currently taking

WOMEN ONLY: Are you pregnant?

◯ Yes ◯ No

If Yes, when is the due date?

Your Primary Care Physician's name, address, & phone number:

Please mark any of the following to indicate YES in response to the question:

☐ Have you ever been told to take antibiotics prior to dental treatment?

☐ Have you ever had complications following dental treatment?

☐ Within the past year, have there been any changes in your general health?

If Yes, Please Explain:

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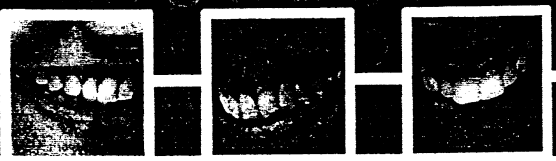

What is the reason for your dental visit today?

When was your last visit to the dentist (if to a different office)?

Prior Dentist's name, address, & phone number:

How frequently do you brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1 - 6 monthly ◯ Seldom ◯ Never

Please mark any of the following to indicate Yes in response to the question:

☐ Do your gums bleed when you brush or floss?

☐ Do your teeth experience sensitivity to cold or hot temperatures?

☐ Are any of your teeth currently causing you pain?

☐ Do you grind your teeth (either consciously or during sleep)?

☐ Do you currently have any dental implants, dentures, or partials?

If you could change anything about your mouth, teeth, or smile, what would it be?

I have completed the health questionaire to the best of my knowledge. I declare all answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian (responsible party): _____

Relationship to Patient: _____