PATIENT REGISTRATION

DATE _____

Patient Information

_____ _____ _____

First Name Middle Initial Last Name

Address _____ Preferred Name _____

City, State, Zip_____ Email _____

Hm Phone# _____ Wk Phone# _____ Cell Phone# _____

Date of Birth _____ Social Security# _____ Drivers Lic# _____

Sex: ❍ Male ❍ Female

Responsible Party

_____ _____ _____

First Name Middle Initial Last Name

Address _____ Sex: ❍ Male ❍ Female

City, State, Zip_____ Email _____

Hm Phone# _____ Wk Phone# _____ Cell Phone# _____

Date of Birth _____ Social Security# _____ Drivers Lic# _____

Marital Status: ❍ Married ❍ Single ❍ Divorced ❍ Widowed

Spouse's Name _____

Hm Phone# _____ Wk Phone# _____ Cell Phone# _____

Date of Birth _____ Social Security# _____ Drivers Lic# _____

Primary Insurance Information

_____ _____ _____

Name of Insured Social Security # Date of Birth

Patient relationship to insured: Self Spouse Child Other

Employer Name_____ Insurance Co. Name _____

Address _____ Address _____

City, State, Zip _____ City, State, Zip _____

GROUP # _____MEMBER ID#_____

Secondary Insurance Information

_____ _____ _____

Name of Insured Social Security # Date of Birth

Patient relationship to insured: Self Spouse Child Other

Employer Name_____ Insurance Co. Name _____

Address _____ Address _____

City, State, Zip _____ City, State, Zip _____

GROUP # _____MEMBER ID#_____

Emergency Contact: **NOT LIVING IN SAME HOUSE**

Name _____

Phone # _____ Relationship to Patient _____

How Did You Choose Brown Dental Associates, P.C? _____

If by referral, who can we thank? _____

Please list people to whom we are authorized to give information about you, their relationship to you, and an identifier only that person will know (ie: phone #, date of birth, etc)

Name _____ Relationship_____ Identifier_____

Name _____ Relationship_____ Identifier_____

SIGNATURE ON FILE

Initial ____ 1. HEALTH UPDATE - I understand it is my responsibility to inform my dental healthcare provider of any and all health/medical or medication changes since my last visit. *(Your signature at the bottom of this page will acknowledge your update.)*

Initial ____ 2. MINOR CHILD TREATMENT RELEASE - I give permission to Doctors of Brown Dental Associates, P.C. and/or their designated assistant or hygienist to perform any and all dental techniques and procedures including the administration of dental anesthetics on my minor child(ren), whether or not I am present at the actual appointment when the treatment is rendered. *(Your signature at the bottom of this page is permission for release of treatment.)*

Initial ____ 3. HIPAA - The Health Insurance Portability and Accountability Act (HIPAA) are now in effect as required by the Federal Government. A copy of our Privacy Policy is available for you to read if you choose to. We will also provide you with your own copy if you would like one. *(Your signature at the bottom of this page will acknowledge the receipt of notice of privavy practices.)*

Initial ____ 4. INFORMATION RELEASE - I authorize the release of any information necessary to hospitals, doctors office, dental office, pharmacy, and/or to file claims for insurance benefits. *(Your signature at the bottom of this page will allow us to share without a signature on each individual form.)*

Initial ____ 5. INSURANCE AUTHORIZATION - I assign directly to Brown Dental Associates, P.C. all dental insurance benefits paid for services rendered. I understand that I am financially responsible for all fees incurred. *(Your signature at the bottom of this page allows assignment.)*

Initial ____ 6. FINANCIAL POLICY - The best dental care can only be maintained through complete understanding of both the dental care required, and the financial arrangements for that care. Our dental office personnel have been trained to assist you with any questions that may arise in these areas.

Initial ____ METHODS OF PAYMENTS: Payment will be discussed at each visit.
The options we offer are:

1. Payment at the time of service: We offer a 5% discount on cash or check payments for amounts more than three-hundred dollars ($300.00). Account balance must be cleared entirely at the time of visit to qualify.
2. We accept *Mastercard*, *Visa, American Express* and *Discover*.
3. We also offer Carecredit so that you may have the dental treatment you need.

Initial ____ DENTAL INSURANCE: Insurance may cover cost of some of your charges. As a service to you, we will submit claims to your insurance company for you but you are ultimately responsible for the entire bill. Since insurance may not cover the entire cost of your service, you are asked to make regular monthly payments to clear any balance within 90 days. Our staff will be happy to assist you in calculating this estimated amount. Should there be an overpayment in the final analysis; the refund will be made directly to you. It is necessary that you provide us with accurate insurance information. You may also be asked in some cases to check with your insurance company on coverage or payment irregularity.

Initial ____ ACCOUNTS: We do not become involved in domestic matters. The parent accompanying any minor will ultimately be held responsible for the account. We will send one bill for services and do not divide account balances. We will help track personal payments to the best of our ability and send reports upon request.

Initial ____ LATE PAYMENT: I understand that I am responsible for charges incurred in accordance with the regular rates and terms of this office, which are available upon request. Should the account become delinquent or be turned over to a collection agency or attorney for collection, the undersigned shall pay all collection agency fees, court costs, late charges, interest and attorney's fees.

Initial ____ LATE PAYMENT CHARGES: Any balance not paid within (60) sixty days of the initial bill shall bear interest at the rate of 1.5% per month. Should you have any questions about your statement, please call the office, we will make every effort to answer and resolve any problems.

Initial ____ MISSED APPOINTMENT FEE: If there is a need to reschedule an appointment, this must be done at least 48 hours prior to the appointment time. Appointments missed or cancelled less than 48 hours in advance will be billed to you at $30 per appointment. (Insurance will not cover missed appointments)
(Your signature at the bottom of this page acknowledges your agreement to our financial policy.)

AGREEMENT SIGNATURE_____ **Date**_____

HEALTH QUESTIONNAIRE

Name _____ Birth date _____

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Circle yes or no, whichever applies, in response to the following questions. Your answers are for our records only and will be considered confidential.

DENTAL

1. Are you having any discomfort at this time? ..... Yes No
2. Have you ever had any serious trouble associated with previous dental treatment? ..... Yes No
   If so, please explain: _____
3. Does dental treatment make you nervous? No_____ Slightly_____ Moderately_____ Extremely_____
4. Date of last dental visit _____
5. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ..... Yes No
   If so, when? _____
6. How often do you brush?_____
   Brush is: Soft ☐ Medium ☐ Hard ☐
7. Do you have or have you ever had any of the following?

MOUTH			TEETH		
Bleeding, sore gums	Yes	No	Loose teeth	Yes	No
Unpleasant taste/bad breath	Yes	No	Sensitive to hot	Yes	No
Burning tongue/lips	Yes	No	Sensitive to cold	Yes	No
Frequent blisters, lip/mouth	Yes	No	Sensitive to sweets	Yes	No
Swelling/lumps in mouth	Yes	No	Sensitive to biting	Yes	No
Ortho treatments (braces)	Yes	No	Food impaction	Yes	No
Biting cheeks/lips	Yes	No	Clenching/grinding	Yes	No
Clicking/popping jaw	Yes	No	If so, when? _____		
Difficulty opening or closing jaw	Yes	No	Shifting in bite	Yes	No

8. Do you use the following? ..... Change in bite ..... Yes No
   Brush ..... Yes No
   Dental floss ..... Yes No
   Fluoride rinse ..... Yes No
   Other _____

MEDICAL

1. Has there been any change in your general health within the past year? ..... Yes No
2. My last physical examination was on _____
3. Are you now under the care of a physician? ..... Yes No
   If so, what is the condition being treated?_____
4. The name and address of my physician is _____
   _____
5. Have you had any serious illness within the past five (5) years? ..... Yes No
   If so, what was the illness? _____
6. Have you been hospitalized or had an operation within the past five (5) years? ..... Yes No
   If so, what was the problem?_____
7. Do you have or have you had any of the following diseases or problems:
   a. Rheumatic fever or rheumatic heart disease? ..... Yes No
   b. Congenital heart disease? ..... Yes No
   c. Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary insufficiency, coronary occlusion, high/low blood pressure, arteriosclerosis, stroke, etc.)? ..... Yes No
      1) Do you have pain in chest upon exertion? ..... Yes No
      2) Are you ever short of breath after mild exercise? ..... Yes No
      3) Do your ankles swell? ..... Yes No
      4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep? ..... Yes No
   d. Artificial or replacement valves? ..... Yes No
   e. Pacemaker? ..... Yes No
   f. Allergy? ..... Yes No
   g. Sinus trouble? ..... Yes No
   h. Asthma or hay fever? ..... Yes No
   i. Hives or a skin rash? ..... Yes No
   j. Fainting spells or seizures? ..... Yes No
   k. Diabetes? ..... Yes No
      1) Do you have to urinate (pass water) more than six times a day? ..... Yes No
      2) Are you thirsty much of the time? ..... Yes No
      3) Does your mouth frequently become dry? ..... Yes No

(continued...)

l. Hepatitis, jaundice or liver disease? ..... Yes No
m. Arthritis or inflammatory rheumatism? ..... Yes No
n. Artificial or replacement joints, prosthetic? ..... Yes No
o. Digestive system—Ulcers or stomach disorders (colitis)? ..... Yes No
p. Kidney trouble? ..... Yes No
q. Tuberculosis? ..... Yes No
r. Persistent cough or cough up blood? ..... Yes No
s. Immune System disorders (including AIDS, HIV, ARC)? ..... Yes No
t. Venereal disease? ..... Yes No
u. Other? _____

8. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? ..... Yes No
   a. Do you bruise easily? ..... Yes No
   b. Have you ever required a blood transfusion? ..... Yes No
   If so, explain the circumstances & when: .....
9. Have you ever tested positive for the AIDS virus? ..... Yes No
10. Do you have any blood disorder such as anemia? ..... Yes No
11. Have you had surgery or x-ray treatment for a tumor, growth, or other condition? ..... Yes No
12. Are you taking any of the following:
   a. Antibiotics or sulfa drugs? ..... Yes No
   b. Anticoagulants (blood thinners)? ..... Yes No
   c. Medicine for high blood pressure? ..... Yes No
   d. Cortisone (steroids)? ..... Yes No
   e. Tranquilizers? ..... Yes No
   f. Antihistamines? ..... Yes No
   g. Aspirin? ..... Yes No
   h. Insulin, tolbutamide (Orinase) or similar drug for diabetes? ..... Yes No
   i. Digitalis or drugs for heart trouble ..... Yes No
   j. Nitroglycerin ..... Yes No
   k. Other medications ..... Yes No
   l. If "Yes" to any of the above, state drug name, dosage and frequency: _____
13. Are you allergic or have you reacted adversely to:
   a. Local anesthetics? ..... Yes No
   b. Penicillin or other antibiotics? ..... Yes No
   c. Sulfa drugs? ..... Yes No
   d. Barbiturates, sedatives, or sleeping pills? ..... Yes No
   e. Aspirin? ..... Yes No
   f. Iodine? ..... Yes No
   g. Codeine or other narcotics? ..... Yes No
   h. Latex or other? _____ Yes No
14. Do you use any tobacco products? ..... Yes No
   If so, how much per day and what? _____
15. Do you use any alcohol products? ..... Yes No
   If so, how much per day/week/month and what? _____
16. Do you use any caffeinated products (coffee, tea, chocolate, etc.)? ..... Yes No
   If so, how much per day and what? _____
17. Do you have any disease, condition, or problem not listed above that you think I should know about? ..... Yes No
   If so, please explain: _____
   _____
18. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiaton? ..... Yes No
19. Are you wearing contact lenses? ..... Yes No
20. Are you experiencing stress or pressure in your work or at home? ..... Yes No
21. Do you use recreational drugs? ..... Yes No

WOMEN

22. Are you pregnant? ..... Yes No
23. Do you have PMS or problems associated with your menstrual period? ..... Yes No
24. Are you taking birth control or hormone therapy? ..... Yes No

Remarks:

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

_____ _____

Signature of Patient Date Signature of Dentist Date