



## Registration and Health History

### Patient Information

Today's Date: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

SS#: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home # \_\_\_\_\_

Work # \_\_\_\_\_ Cell # \_\_\_\_\_

DL # \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Employer: \_\_\_\_\_

Email: \_\_\_\_\_

Person to contact in an emergency \_\_\_\_\_ Phone # \_\_\_\_\_

If patient is a minor, give parent or guardian's name \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

### Dental Insurance Information

Insured's Name: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Insured's SS#: \_\_\_\_\_ Insured DOB: \_\_\_\_\_

Insured's Address (if different than above): \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Claim's Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Group #: \_\_\_\_\_ Effective Date of Coverage: \_\_\_\_\_

The information above is true and correct to the best of my belief. I authorize any provider of services to furnish any information requested. I also hereby authorize my Dental Plan Administrator to release or obtain from my organization or person information that may be necessary to determine benefits payable under the group benefits with the Dental Benefit Plan. A Photostat copy of this authorization shall be considered as effective and valid as the original.

*Although I have requested the dentist to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure that the bill is paid within 45 days. If for any reason, my insurance company does not pay any portion of my bill, I further agree to make prompt payment of the bill. I understand that I am responsible for all of the charges for all services rendered to me or any member of my family.*

*I hereby authorize payment directly to the provider of the dental benefits otherwise payable to me.*

Signed \_\_\_\_\_ Date \_\_\_\_\_



## Dental History

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Is there anything about your smile you do not like? \_\_\_\_\_

### Are you experiencing any of the following:

- |                                        |                                          |                                            |                                         |                                             |
|----------------------------------------|------------------------------------------|--------------------------------------------|-----------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Bad Breath    | <input type="checkbox"/> Broken Teeth    | <input type="checkbox"/> Hot Sensitivity   | <input type="checkbox"/> Loose Teeth    | <input type="checkbox"/> Migraines          |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Broken Fillings | <input type="checkbox"/> Sweet Sensitivity | <input type="checkbox"/> TMJ Discomfort | <input type="checkbox"/> Earaches/Neck Pain |
| <input type="checkbox"/> Sore Gums     | <input type="checkbox"/> Tooth Pain      | <input type="checkbox"/> Cold Sensitivity  | <input type="checkbox"/> Teeth Grinding | <input type="checkbox"/> Snoring            |

## Medical History

Primary Physician's Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Are you under the care of a specialist (i.e. Cardiologist, etc.)?  Y  N Explain: \_\_\_\_\_

Specialist's Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Have you or are you taking any bisphosphonate drug (i.e. Fosamax, Actonel, Boniva)?  Y  N

Check any of the following that you have had or presently have:

- |                                                 |                                                  |                                                    |                                                 |
|-------------------------------------------------|--------------------------------------------------|----------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Hepatitis A B C         | <input type="checkbox"/> Heart disease or attack   | <input type="checkbox"/> AIDS/HIV               |
| <input type="checkbox"/> Excessive Bleeding     | <input type="checkbox"/> Radiation treatment     | <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> Liver disease          |
| <input type="checkbox"/> Emphysema              | <input type="checkbox"/> Psychiatric disorder    | <input type="checkbox"/> Cardiac Stent             | <input type="checkbox"/> Tuberculosis           |
| <input type="checkbox"/> Mitral Valve Prolapse  | <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Congenital heart failure  | <input type="checkbox"/> Kidney disease         |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Sinus trouble           | <input type="checkbox"/> Heart Murmur              | <input type="checkbox"/> Heart Pacemaker        |
| <input type="checkbox"/> Drug Dependency        | <input type="checkbox"/> Allergies or hives      | <input type="checkbox"/> Heart surgery             | <input type="checkbox"/> Alcoholism             |
| <input type="checkbox"/> Thyroid disease        | <input type="checkbox"/> Blood transfusion       | <input type="checkbox"/> Stroke                    | <input type="checkbox"/> Hemophilia             |
| <input type="checkbox"/> Epilepsy or seizures   | <input type="checkbox"/> Osteoporosis            | <input type="checkbox"/> Blood thinners (Coumadin) | <input type="checkbox"/> Nervousness/Anxiety    |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> History of Endocarditis | <input type="checkbox"/> Rheumatic Fever           | <input type="checkbox"/> Cortisone medicine     |
| <input type="checkbox"/> Fainting               | <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Cosmetic surgery          | <input type="checkbox"/> HPV                    |
| <input type="checkbox"/> Artificial joints      | <input type="checkbox"/> Fever blisters/Ulcers   | <input type="checkbox"/> Tobacco Use               | <input type="checkbox"/> Diabetes Type 1/Type 2 |
| <input type="checkbox"/> Pre-Medicate ( _____ ) |                                                  |                                                    |                                                 |

List all medications you are currently taking, including over the counter and dietary or herbal supplements:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List Allergies: \_\_\_\_\_

Have you ever had a series illness or operation?  Y  N Describe: \_\_\_\_\_

(Woman) Are you pregnant?  Y  N If yes, which trimester: \_\_\_\_\_

Is there any other medical or dental information or experiences that you feel we should know about?  
\_\_\_\_\_  
\_\_\_\_\_

Patient Signature or Parent/Guardian of child: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Financial Policy

We are committed to handling the financial end with you in mind. In order to maintain an ongoing, positive relationship with our patients, we would like to disclose our options for financing procedures for your dental health.

**Payment in full is required at the time services are rendered.  
Please make sure we have your most current insurance information on file.**

For the convenience of our patients, we ask for payment to be made on the day of the appointment. This allows for less confusion and offers the patient to take make financial arrangements in the office.

If you have an insurance plan that our office can accept, we will be glad, as a courtesy, to file to the insurance company for your benefits. We will estimate your copay based on information we obtain from your insurance company. This copay is expected at the time services are rendered. If the insurance company pays less than expected or not at all, we will bill you for the balance. This payment is expected in full upon receipt.

Or, we offer outside financing through Care Credit. It is a credit card that you may apply for. They offer several options for smaller payments and may be used by any member of your family.

Brown Road Dental accepts Visa, MasterCard, and Discover. We can also keep your credit card information securely stored and can automatically run a payment on a designated date. We also welcome your personal checks with proper identification.

**The patient is responsible for any fee(s) incurred due to any associated account(s) becoming delinquent. After 90 days, if an account is not paid in full and/or the patient has not contacted our office with a payment plan that is suitable to both parties, your account will be turned over to an outside collection agency. In the event an account is turned over, the patient will be responsible for payment of any collection costs and/or attorney fees, in addition to the balance owed.**

We thank you for your cooperation in our financial policy. We are dedicated to your oral health and will help you in any way we can.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Notice of Privacy Practices: Patient Acknowledgement

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I have been given the opportunity to receive Brown Road Dental’s Notice of Privacy Practices. I understand that this notice is Federally mandated and that it provides in detail the uses and disclosures of my protected health information that may be made by Brown Road Dental, my individual rights and Brown Road Dental’s legal duties with respect to my protected health information. These include, but are not limited to the following:

- A statement that Brown Road Dental is required by law to maintain the privacy of protected health information.
- A statement that they are required to follow the terms of the notice currently in effect.
- Types of uses and disclosures that can be made for each of the following purposes: Treatment, Payment, and Health Care Operations.
- A description of other situations where disclosure of protected health information is permitted or required without my consent or authorization.
- A description of uses and disclosures that are prohibited or limited by law.
- A description of disclosures that require my written authorization and how I may revoke authorizations.
- My individual rights with respect to protected health information and how I can exercise those rights
- The right to complain to Brown Road Dental and to the Secretary of HHS if my privacy rights have been violated and that no retaliatory actions will be taken because of such a complaint.
- The right to request restrictions of certain uses and disclosures of my protected health. However, I understand Brown Road Dental does not have to agree to honor my requested restrictions.
- The right to receive confidential communications of protected health information
- The limited right to inspect and copy certain protected health information.
- The right to request to amend protected health information.
- The right to request an accounting of disclosures of protected health information.
- The right to obtain a paper copy of the Notice of Privacy Practices from Brown Road Dental upon request.

*I also understand Brown Road Dental reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions for all protected health information that it maintains. Furthermore, if changes are made, I can obtain a revised Notice of Privacy Information upon request.*

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship to Patient** {if signed by a personal representative of patient} \_\_\_\_\_

IF you would like to authorize a person or persons to be able to talk about your treatment or account, please sign below. My treatment and account status may be discussed with \_\_\_\_\_

\_\_\_\_\_  
Date: \_\_\_\_\_

(Relationship)