Brummett Family Dental

Patient Name: _____ Today's Date: _____

Male___ Female___ DOB: ____/____/____ SSN: _____-_____-_____

Phone number: (_____) _____-_____ Alternate phone #: (_____)_____-_____

Address: _____

City: _____ State: _____ ZIP: _____

Place of Employment: _____ Email: _____

Name of Parent/Guardian: _____

Phone: (_____) _____-_____ Relationship to Patient: _____

Dental insurance information- *we no longer accept new patient Medicaid.*

Insurance Name: _____ Ins Phone #:_____

Subscriber Name: _____

Subscriber DOB:_____ Subscriber SSN: _____

Dental Information

Reason for Today's Visit: _____

How Often do You Brush? _____ How Often do You Floss? _____

Medical Information

Primary Care Physician: _____ Pharmacy:_____

Are you Pregnant:_____ Due Date: _____

Do You Smoke Tobacco: _____ Are you allergic to Tree Nuts: _____

Allergies:

_____

_____

Surgeries: *(or provide list)*

_____

_____

Medications: *(or provide a list)*

_____

_____

Please Check Any of the Following Dental Conditions that Apply

- ❑ Sensitive teeth
- ❑ Bleeding gums
- ❑ Food impaction
- ❑ Pain around ears
- ❑ Swelling
- ❑ Unusual sound while chewing
- ❑ Snoring
- ❑ Blisters on lips
- ❑ Clenching or grinding
- ❑ Wear dentures or partial plates
- ❑ Burning tongue
- ❑ Bad breath
- ❑ Dry mouth
- ❑ Loose teeth
- ❑ Tooth decay

Please Check any of the following that you may have or ever had (please list the year of diagnosis)

- ❑ Abnormal bleeding
- ❑ Aids/ HIV
- ❑ COPD
- ❑ Epilepsy
- ❑ High/ Low blood pressure
- ❑ stroke
- ❑ Heart attack
- ❑ Chemotherapy/ Radiation
- ❑ Steroid treatments
- ❑ Anxiety/depression/PTSD
- ❑ Anemia
- ❑ Diabetes (Type 1, 2)
- ❑ Fainting
- ❑ Angina
- ❑ Hemophilia/Clotting factor
- ❑ STD
- ❑ HEP (Type A, B, C)
- ❑ Auto-immune Disease
- ❑ Arthritis
- ❑ Cancer
- ❑ Intrathecal pain pump
- ❑ ADHD
- ❑ Autism
- ❑ Artificial joints

- ❑ Kidney dialysis
- ❑ Thyroid problems
- ❑ Tb (tuberculosis)
- ❑ Asthma
- ❑ Osteoporosis
- ❑ Sleep apnea: CPAP

Please list any medical conditions not listed:

_____

_____

We ask that you disclose as much information with us as possible to make sure that you receive the best care possible. The best dental health services are based on friendly and mutual understanding between staff, providers, and patients. We also encourage you to ask any questions about your treatment and our services.

HIPAA Consent:

I, _____ understand that by signing this consent, I authorize Brummett Family Dentistry to use and disclose my protected health information to carry out direct and indirect treatment. I have also been informed of my patient rights and understand that I have the right to review and secure a copy of my protected health information.

Sign: _____ Date_____

Financial Consent:

Self-pay: I am responsible for any fees due for treatment on the day of service.

Insurance: I authorize Brummett Family Dentistry to file any dental claims with my current dental insurance company and will pay any co-payment or deductible on the day of service.

I am responsible for providing any changes or updates of my current dental insurance prior to my visit.

Sign: _____ Date_____

Office policies:

Here at Brummett Family Dentistry, we take pride in our work and strive to provide the best care possible. We ask that you read over our policies to fully understand our goal to provide an excellent dental experience for you.

1. We require patients to update us with any dental insurance changes prior to dental treatment.
2. Insurance copays, deductibles, or balance of treatment without insurance are due at the time of your dental visit.
3. We ask that you update us with any changes to your medical history and medicines at each vi
4. Reminder calls are a curtesy, you are responsible for keeping up with your own appointment time.
5. After three missed appointments without a call, patients will be dismissed.
6. We have the right to refuse to treat and/or dismiss a patient at our discretion.

Sign: _____ Date_____

List of emergency contacts (HIPAA):

Please be advised that by providing this information, you are allowing us to discuss minimal patient information to whomever is listed below.

1. Name: _____

   Relationship: _____

   Phone Number: _____

2. Name: _____

   Relationship: _____

   Phone Number: _____

3. Name: _____
   Relationship: _____
   Phone Number: _____