BROWN FAMILY DENTISTRY

Welcome to Brown Family Dentistry – Tell Us About Yourself

Patient Information

Name: ____
Last First MI Title

Preferred Name: ______________________________ ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

Address: ____________________City______________State__________Zip______

SSN: ______________________ DOB: ______________________

Home Phone: ______________________ Work Phone: ______________________

Cell Phone: ______________________ Email Address: ______________________

Employer: ______________________ Occupation: ______________________

How did you hear about our office? ______________________________

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☐ **Spouse** ☐ **Parent Information (*If parent information, fill both name sections complete)**

Name ______________________ *Name______________________

Address______________________ *Address______________________

City__________St______Zip________ * City__________St______Zip________

Hm Ph__________ Cell__________ * Hm Ph__________ Cell__________

Soc. Sec#__________ DOB__________ * Soc. Sec#__________ DOB__________

Employer______________________ *Employer______________________

Insurance – Primary

Subscriber Name: ______________________

Subscriber DOB:______________________

Subscriber SSN/ID: ______________________

Subscriber Employer: ______________________

Insurance Company Name: ______________________

Group Number: ______________________

Insurance – Secondary

Subscriber Name: ______________________

Subscriber DOB:______________________

Subscriber SSN/ID: ______________________

Subscriber Employer: ______________________

Insurance Company Name: ______________________

Group Number: ______________________

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Brown Family Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: ____

Relationship: ______________________________ Date: ______________________

BROWN FAMILY DENTISTRY

Medical History

Do you have a family physician? ☐ Yes ☐ No

Physician's Name: _____

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

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Are you taking any medications? ☐ Yes ☐ No

Please list: _____

Have you ever had any surgical procedures? ☐ Yes ☐ No

Please list: _____

Conditions

Yes	No		Yes	No		Yes	No	
☐	☐	Abnormal bleeding	☐	☐	Epilepsy	☐	☐	Kidney Problems
☐	☐	Alcohol Abuse	☐	☐	Facial Surgery	☐	☐	Liver Disease
☐	☐	Allergies	☐	☐	Fainting Spells	☐	☐	Low Blood Pressure
☐	☐	Anemia	☐	☐	Fever Blisters	☐	☐	Pace Maker
☐	☐	Angina Pectoris	☐	☐	Frequent Headaches	☐	☐	Psychiatric Problems
☐	☐	Arthritis	☐	☐	Glaucoma	☐	☐	Radiation Therapy
☐	☐	Artificial Heart Valve	☐	☐	HIV+/AIDS	☐	☐	Rheumatic Fever
☐	☐	Asthma	☐	☐	Heart Attack	☐	☐	Seizures
☐	☐	Blood Transfusion	☐	☐	Heart Murmur	☐	☐	Sexually Transmitted Diseases
☐	☐	Cancer	☐	☐	Heart Surgery	☐	☐	Shingles
☐	☐	Chemotherapy	☐	☐	Hemophilia	☐	☐	Sickle Cell Disease
☐	☐	Congenital Heart Defect	☐	☐	Hepatitis A	☐	☐	Sinus Problems
☐	☐	Diabetes	☐	☐	Hepatitis B	☐	☐	Stroke
☐	☐	Difficulty Breathing	☐	☐	Hepatitis C	☐	☐	Thyroid Problems
☐	☐	Drug Abuse	☐	☐	High Blood Pressure	☐	☐	Tuberculosis
☐	☐	Emphysema	☐	☐	Joint Replacement	☐	☐	Ulcers

Allergies

Yes	No		Yes	No		Yes	No	
☐	☐	Aspirin	☐	☐	Erythromycin	☐	☐	Metals
☐	☐	Codeine	☐	☐	Jewelry	☐	☐	Penicillin
☐	☐	Dental Anesthetics	☐	☐	Latex	☐	☐	Tetracycline

Do you smoke? ☐Yes ☐ No How much? _____

If Female, please answer:

Are you taking birth control medication? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No If so, how many weeks? _____

Are you nursing? ☐ Yes ☐ No

Nearest relative not living with you:

Name and relationship _____ Phone # _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature _____ Date _____

BROWN FAMILY DENTISTRY

Dental History

How may we help you today? _____

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had gum surgery? ☐ Yes ☐ No

Do you now or have you had any pain/discomfort in your jaw joint (TMJ)? ☐ Yes ☐ No

Are you under stress? ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

Is there anything you would like to change about your smile? ☐ Yes ☐ No

Are you happy with the color of your teeth? ☐ Yes ☐ No

Do your gums bleed? ☐ Yes ☐ No

How many times do you: floss/week? _____ brush/day? _____

Are your teeth sensitive to hot, cold or anything else? ☐ Yes ☐ No

Have you lost any teeth? ☐ Yes ☐ No

Have you ever had a serious/difficult problem with any previous dental work? ☐ Yes ☐ No

Have you ever had an unfavorable dental experience? ☐ Yes ☐ No

When was your last dental cleaning? _____

When was your last dental visit? _____

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit? _____

At Brown Family Dentistry we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below that you would like our doctors to discuss with you during your visit.

Veneers	Invisalign	
Smile Makeover	Cosmetic Bonding	Dentures
Crown and Bridge	Implants and Implant Crowns	Partials

BROWN FAMILY DENTISTRY

Insurance and Financial Policy

At Brown Family Dentistry, we believe that you deserve the best care. That is why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits, but some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know:

Initial

_____ Your dental benefits are based upon a contract between your employer and an insurance company. **If you have questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.**

_____ We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service.) This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE. If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment but will give you the exact out of pocket figures you may require.

_____ We will bill your insurance as a courtesy. If insurance does not pay within 90 days, Brown Family Dentistry reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. Ultimately, you are responsible for all charges incurred in our office.

_____ Brown Family Dentistry does require payment in full for your portion at the time of service. We accept MasterCard, Visa, Discover, cash, and checks. There is a $25 fee for returned checks. If you are in need of an extended finance option, we also work with Citi Health financing. I understand a finance charge of 6% (72% per annum) will be added to my account should the balance become 30 days delinquent.

_____ I understand that if any unpaid balance is assigned to a third party collection agency for collection or placed with an attorney to obtain judgment or otherwise satisfy payment of my account, a collection fee equal to 33 1/3% of the unpaid balance will be added to my account. I agree to pay that fee. I further agree to pay reasonable attorney fees and court costs if a judgment is granted against me. I authorize Brown Family Dentistry and any of its agents to contact me by telephone, at any of the numbers provided including any wireless number for me and/or my spouse, which could result in charges to me/us. I acknowledge that my spouse or I may also be contacted by sending text messages, and/or emails, using any email addresses provided. Furthermore, I also authorize methods of contact may include using pre-recorded and/or artificial voice messages and/or automatic dialing devices, as applicable.

_____ A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24 hour notice to avoid a **$40/hour cancellation fee** (emergencies are an exception). If appointments are repeatedly canceled or rescheduled, you will no longer be allowed to pre-appoint your visits. You would be required to call in the same day to check availability.

CONSENT FOR DENTAL SERVICES

I hereby request and authorize Dr. Wes Brown or Dr. Jessica Brown and his/her auxiliaries to perform for me all dental treatment and surgery as indicated in my dental records and to do whatever procedures that are deemed advisable and have been approved by me. I also authorize the administration of anesthetics that may be deemed advisable by the above named doctor.

I agree with the above conditions.

Print Name: _____ Date: _____

Patient/Guardian Signature: _____