Brummett Family Dental

Patient Name: _____ DOB: ___/____/____

Social Security Number: _____-_____-_____ Phone number: (_____)_____-_____

Address: _____ State: ____ ZIP: _____

Place of Employment: _____

Information for the parent or guardian

Name: _____ Phone: (_____)_____-_____

Relationship to Patient: _____

In case of an emergency – name of the closest relative who does not live with you

Name: _____ Phone: (____)_____-_____

Dental insurance information- we no longer accept new patient Medicaid

Insurance Name: _____

Subscriber Name: _____

Identification Number: _____

Dental Information

Reason for Today's Visit: _____

How Often do You Brush? _____

How Often do You Floss? _____

Medical Information

Primary Care Physician: _____

Are you Pregnant: YES/NO If you circled Yes, when is the Due Date: _____

Do You Smoke Tobacco: YES/NO Are you allergic to Tree Nuts: YES/NO

List of any Allergies:

_____

_____

List of any Recent Surgeries:

_____

_____

List of any medications (If you have your own list, please provide this information to the front desk):

_____

_____

Please Check Any of the Following Dental Conditions that Apply to You

- ❑ Sensitive teeth
- ❑ Bleeding gums
- ❑ Food impact
- ❑ Pain around ears
- ❑ Swelling or lump in throat/ mouth
- ❑ Unusual sound while chewing
- ❑ Snoring
- ❑ Blisters on lips
- ❑ Clenching or grinding
- ❑ Wearing 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
- ❑ Artificial heart defect
- ❑ Cardiac arrest
- ❑ COPD
- ❑ Epilepsy
- ❑ Heart murmur
- ❑ High/ Low blood pressure
- ❑ stroke
- ❑ Heart attack
- ❑ Chemotherapy/ radiation
- ❑ Silke cell anemia
- ❑ Steroid treatments
- ❑ Anxiety/depression/PTSD
- ❑ Liver disease
- ❑ Anemia
- ❑ Diabetes (Type 1, 2)
- ❑ Fainting
- ❑ Hemophilia
- ❑ STD
- ❑ HEP (Type A, B, C)
- ❑ Lupus
- ❑ Arthritis
- ❑ Cancer (Type_____)
- ❑ Intrathecal pain pump
- ❑ ADHD
- ❑ Breathing problems
- ❑ Congenital heart disease

- ❑ Artificial joints
- ❑ Kidney dialysis
- ❑ Thyroid problems
- ❑ Tb (tuberculosis)
- ❑ Asthma
- ❑ Stem cell transplant
- ❑ Sleep apnea: CPAP

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

Sign: _____

HIPPA Consent:

I, _____ understand that by signing this consent, I authorize Brummett Family Dentistry to use and disclose my protected health information to carry out treatment including 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: _____

Financial Consent:

I, _____are authorized Brummett Family Dentistry to file any dental claims with my insurance company. COPAYMENT AND COLLECTION: I also understand that the front desk will ask for any necessary copays or deductibles and that I am personally responsible for what my insurance does not pay and to bring the correct amount and form of payment to every appointment.

Sign: _____

Office policies:

Here at Brummett family dentistry we pride ourselves in our work and strive to provide the best care possible! We ask that you read over our policies to fully understand our goal for providing a better dental experience for you.

1. Reminder calls are a curtsy, you are responsible for keeping up with your own appointment time.
2. Copays, deductibles, and your part for any dental work will be due at time of visit.
3. We require patients to update us with any dental insurance changes.
4. If you or someone needs to reschedule their appointment, we require 24 hours' notice for cancellations. Failure to do so will result in dismissal.

Sign: _____