



## WELCOME!

Patient's Full Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Gender:  M  F Date of Birth: \_\_\_\_\_ Marital Status:  Single  Married  Divorced  Widowed

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_ SSN: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Responsible Party's Name (if different from above): \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about our clinic?  Drive-by  Internet Search  Family/Friend: \_\_\_\_\_

Other: \_\_\_\_\_

### Primary Dental Insurance

Policy Holder: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Employer/Group Name: \_\_\_\_\_

Group Number: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Member ID or SSN: \_\_\_\_\_

### Secondary Dental Insurance

Policy Holder: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Employer/Group Name: \_\_\_\_\_

Group Number: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Member ID or SSN: \_\_\_\_\_

**HIPAA Acknowledgement:** I understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. Your personal health information will not be shared. I acknowledge that I have been provided with and understand this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement; this facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

**Scheduling and Missed Appointments:** When you schedule an appointment with our office, our team takes time to prepare in anticipation of serving you - including setting up your treatment room, reviewing your health history, and adding special touches to make your visit comfortable. If you need to reschedule an appointment, we kindly request that you contact us by phone with advanced notice of two business days.

We understand that conflicts arise; however, failing to attend your appointment or canceling without adequate notice more than 3 times will result in a \$75 charge per appointment. By notifying us early that you need to change your appointment will make it possible for us to offer your appointment time to another patient. We appreciate your cooperation.

**Patient/Responsible Party Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Although dental personnel primarily treat the area in/around your mouth, your mouth is a part of your entire body. Health problems you have, or medication that you take, could have an important relationship with the dentistry you will receive.

Yes  No Do you see a physician on a regular basis? If yes, please explain: \_\_\_\_\_

Yes  No Have you ever been hospitalized or had a major operation? If yes, please explain: \_\_\_\_\_

Yes  No Have you ever had a serious head or neck injury? If yes, please explain: \_\_\_\_\_

Yes  No Are you taking any medications, pills, or drugs? If yes, please list: \_\_\_\_\_

Are you allergic to any of the following? If yes, please check all that apply:

Aspirin  Penicillin  Codeine  Local Anesthetics  Acrylic  Metal  Latex  Sulfa Drugs

Other: \_\_\_\_\_

Yes  No Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?

Yes  No Do you take, or have you taken, Phen-Fen or Redux?

Yes  No Are you on a special diet?

Yes  No Do you use tobacco products?

Yes  No Do you use controlled substances?

Do you, or have you, had any of the following? Please check all that apply:

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> AIDS/HIV Positive         | <input type="checkbox"/> Arthritis/Gout/<br>Rheumatism | <input type="checkbox"/> Artificial Heart Valve   | <input type="checkbox"/> Anemia                |
| <input type="checkbox"/> Angina                    | <input type="checkbox"/> Blood Disease                 | <input type="checkbox"/> Blood Transfusion        | <input type="checkbox"/> Artificial Joint      |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Cancer                        | <input type="checkbox"/> Chemotherapy             | <input type="checkbox"/> Breathing Problems    |
| <input type="checkbox"/> Bruise Easily             | <input type="checkbox"/> Congenital Heart Disorder     | <input type="checkbox"/> Convulsions              | <input type="checkbox"/> Chest Pains           |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Easily Winded                 | <input type="checkbox"/> Emphysema/COPD           | <input type="checkbox"/> Diabetes/Hypoglycemia |
| <input type="checkbox"/> Drug Addiction            | <input type="checkbox"/> Excessive Thirst              | <input type="checkbox"/> Fainting                 | <input type="checkbox"/> Epilepsy/Seizures     |
| <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Frequent Headaches            | <input type="checkbox"/> Spells/Dizziness/Vertigo | <input type="checkbox"/> Frequent Cough        |
| <input type="checkbox"/> Frequent Diarrhea         | <input type="checkbox"/> Heart Pacemaker               | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Heart Attack/Failure  |
| <input type="checkbox"/> Heart Murmur              | <input type="checkbox"/> Hepatitis B or C              | <input type="checkbox"/> Heart Trouble/Disease    | <input type="checkbox"/> Hemophilia            |
| <input type="checkbox"/> Hepatitis A               | <input type="checkbox"/> Hives or Rash                 | <input type="checkbox"/> Herpes Simplex Virus     | <input type="checkbox"/> High Blood Pressure   |
| <input type="checkbox"/> High Cholesterol          | <input type="checkbox"/> Liver Disease                 | <input type="checkbox"/> Irregular Heartbeat      | <input type="checkbox"/> Kidney Problems       |
| <input type="checkbox"/> Leukemia/Lymphoma         | <input type="checkbox"/> Multiple Sclerosis            | <input type="checkbox"/> Low Blood Pressure       | <input type="checkbox"/> Lung Disease          |
| <input type="checkbox"/> Mitral Valve Prolapse     | <input type="checkbox"/> Psychiatric Care              | <input type="checkbox"/> Osteoporosis             | <input type="checkbox"/> Pain in Jaw Joints    |
| <input type="checkbox"/> Parathyroid Disease       | <input type="checkbox"/> Rheumatic                     | <input type="checkbox"/> Radiation Treatment      | <input type="checkbox"/> Recent Weight Loss    |
| <input type="checkbox"/> Renal Dialysis            | <input type="checkbox"/> Fever/Rheumatic               | <input type="checkbox"/> Sexually Transmitted     | <input type="checkbox"/> Shingles              |
| <input type="checkbox"/> Sickle Cell Disease       | <input type="checkbox"/> Heart Disease                 | <input type="checkbox"/> Infection                | <input type="checkbox"/> Stroke                |
| <input type="checkbox"/> Swelling of Limbs         | <input type="checkbox"/> Sinus Trouble                 | <input type="checkbox"/> Stomach/Intestinal       | <input type="checkbox"/> Tuberculosis          |
| <input type="checkbox"/> Tumors or Growths         | <input type="checkbox"/> Thyroid Disease               | <input type="checkbox"/> Disease                  | <input type="checkbox"/> Cortisone Medicine    |
| <input type="checkbox"/> Ulcers                    | <input type="checkbox"/> Anaphylaxis                   | <input type="checkbox"/> Tonsillitis              |  |
| <input type="checkbox"/> Alzheimer's Disease       |  | <input type="checkbox"/> Yellow Jaundice          |  |

**Women:** Are you pregnant:  Yes  No Nursing?  Yes  No Taking Oral Contraceptives?  Yes  No

In the unlikely event that a member of our staff is exposed to my blood or body fluids through a needle stick, skin cut, or splash to the eyes/mouth area, I agree to have my blood tested (free of charge) for blood borne diseases.  Yes  No

**Patient/Responsible Party Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

It is our desire to provide the highest quality dental care to all of our patients. Our office wants all of our patients to be able to comfortably afford their dental care for teeth, gums, and bones to last a life time. We proudly offer the following practice policies so that our patients can have the opportunity to decide which treatment and payment options will best suit their individual needs. We ask that you please read, agree to, and sign before any treatment is rendered.



**Dental Insurance:**

Please be prepared to show your current dental insurance card and a valid photo ID at each visit.

Your insurance is a contract between you, your employer (if applicable) and the insurance company. At our practice, we will file your insurance claim for you. As a courtesy, we will assist you with information, however, if you have any additional questions about coverage, please contact your insurance company or human resources department.

Our goal is to maximize your insurance benefits. Please remember that insurance is not deigned to cover 100% of the cost of all types of dental treatment. At the time of treatment, the patient/guarantor is responsible for the estimated portion that the insurance does not cover (also called "copay").

Treatment recommended by our dental professionals is never based on what your insurance company will pay, but on what our team feels is best for your overall dental health. We request that you understand your benefit plan and be familiar with the dental benefits covered by your insurance in advance of your appointment so that together we can make the best treatment decisions for you.

**Initial: \_\_\_\_\_ I consent**  
**\_\_\_\_\_ I do not have dental insurance.**

**Financial Considerations**

At our practice, we strive to provide patients with comfortable financing options for affording their dental treatment. Payment arrangements are required before beginning any treatment that is not covered 100% by dental insurance. The payment options available to you are:

- PAYMENT IN FULL: Payment is due at the time of the appointment.
- AUTO-PAY: For treatment exceeding \$100.00, our office offers an auto-payment plan on your credit or debit card. 50% of the total cost of treatment is processed on the day that treatment begins, and a 25% monthly payment is processed until the account is paid in full.
- THIRD PARTY FINANCING: CARE CREDIT or LENDING CLUB offers deferred interest for larger treatment plans. A minimum purchase is required, and subject to credit approval. For more information, visit: [www.carecredit.com](http://www.carecredit.com)

By signing this agreement, the patient agrees with the office of Brenner Dental Group DDS PLLC that any dispute relating to dental care services rendered for any conditions, including any services rendered prior to the date this agreement was signed, and any dispute arising out of the diagnosis, treatment, or care of the patient, shall be resolved by binding arbitration. The patient understands that the result of this arbitration agreement is that claims, including malpractice claims he/she may have against the doctor, cannot be brought as the lawsuit in court before a judge or jury, and agrees that all such claims will be resolved as described in this section.

I agree to pay fees and expenses incurred by Brenner Dental Group PLLC to collect on this account. I understand that all balances 60 days and older are subject to interest at 1.5% monthly/18% annually. It is agreed and understood that if this obligation should become delinquent that I, the patient or guarantor party agree to pay the collection costs and costs associated with placing my obligation to a collection agency and/or attorney for litigation.

**Initial: \_\_\_\_\_ I consent**

**Patient/Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_**