Dr. Corey J. Brenner, DDS Dr. Nicole L. Tripp, DDS

Welcome to our dental practice! We realize that you have many options when it comes to dental providers, so we are pleased that you have chosen us to care for your dental needs. We are committed to providing you with high quality dental care in a compassionate, gentle manner.

On your first visit, you can expect:
- A thorough oral examination, including only the necessary x-rays
- A professional preventative cleaning
- A discussion of the most appropriate treatment to meet your oral health goals.

As always, your personal health information will be kept private in accordance with HIPAA Privacy regulations.

Enclosed, you will find our registration, health history, and office policies forms. Please complete them at your convenience and bring them with you to your first appointment.

If you have had x-rays taken within the last three years, please fill out the Records Release and return it to our office as soon as possible so we can acquire your records prior to your first visit. If we do not have current x-rays at your first appointment, we will be taking new x-rays at that visit in order to properly complete a comprehensive exam. You can expect to have the BITEWING x-rays taken once every 12 months, and the PANORAMIC or FULL SERIES x-rays once every 3-5 years.

Also, if you have dental insurance, please bring your dental insurance card so we may update your account properly. You will also be asked to provide a photo ID at your first visit.

You can check us out at Facebook.com/BrennerDental or www.BrennerDentalGroupMN.com!

We look forward to meeting you at your appointment! If you have any questions, please email or call our office.

Sincerely,

Brenner Dental Group

102 Marty Drive Suite 3
Buffalo, Minnesota 55313
P: 763-682-2101 F: 763-682-5069
WWW.BRENNERDENTALGROUPMN.COM

106 ½ Broadway Street
Monticello, Minnesota 55362
P: 763-682-2101 F: 763-682-5069
OFFICE@BRENNERDENTALGROUPMN.COM

REGISTRATION

Patient's First Name:_____Last Name:_____MI: _____

Preferred Name (if different from above): _____

Address:_____City:_____State:____Zip:_____

Home Phone:_____Cell Phone: _____

Sex: □ Male □ Female Date of birth: _____ Soc. Sec.: _____

Emergency Contact Name:_____Phone #: _____

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

How did you hear about our practice? _____

Text Messaging & Email Consent

I hereby give my consent for Brenner Dental Group to send text message reminders to my mobile telephone and/or email correspondence. These messages will be a reminder of my previously booked appointment date and time, or a notification that I need to schedule an appointment. NOTE: If you choose to sign up for text messages be aware that standard text messaging rates will apply as defined in your wireless service agreement.

Receive text messages? _____YES _____NO Cell #: _____

Receive email messages? _____YES _____NO Email: _____

HIPAA Privacy 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. 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.

Initials: _____

Personal Representative Authorization for Medical/Dental Release (OPTIONAL)

I authorize this facility to speak to the following family members or my personal representative(s) regarding (check one):

- ○ All medical/dental history information, billing records, x-rays, and any other information in my file.
- ○ Only the following types of information: _____

Family Member/Rep:_____Relationship:_____

Family Member/Rep:_____Relationship:_____ I understand that I may terminate this Medical Authorization form. I must notify this facility in writing regarding termination and effective date. I know that I am entitled to receive a copy of this agreement.

Signature of **PATIENT**, **PARENT** or **GUARDIAN**:_____Date:_____

MEDICAL HISTORY

Patient's Name:_____ DOB: _____

○ Yes ○ No Do you see a physician on a regular basis?

○ 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: _____

_____

○ Yes ○ No 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 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 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?

Women: Are you Pregnant? ○ Yes ○ No Nursing? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No

Do you have, or have you had, any of the following? (Check all that apply)

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

Have you ever had any serious illness not listed above? Yes ○ No ○ If yes, please explain: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health as health problems I may have, or medications I am taking, can have important interrelationships with the dentistry I will receive.

It is my responsibility to inform the dental office of any changes in medical status.

Signature of **PATIENT**, **PARENT**, or **GUARDIAN**:_____ Date: _____

OFFICE POLICIES

(Please initial all sections)

_____ **Cancellation Policy**: If you are unable to keep an appointment, we ask that you kindly provide us with a minimum of two business days' notice. This courtesy on your part will make it possible to give your appointment to another patient. Please note that after three failed or cancelled less than 2 business days' appointments, your account will be charged $75.

_____ **Treatment recommended by our providers is never based on what your insurance company will pay.** We request that you understand and are familiar with your benefit plan so that together we can make the best treatment decisions. If you have any questions about your coverage, we encourage you to call your insurance company to learn more about your coverage.

_____ **Your insurance is a contract between you and your employer and the insurance company**. We are not a party to that contract. 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.

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

_____ **Brenner Dental Group bills insurance as a courtesy to our patients**. Regardless of whether we file your insurance claim, you are ultimately financially responsible for all services rendered. It is the patient/guarantor's responsibility to provide any new information regarding insurance.

_____ **Payment Options and 3rd Party Financing/CareCredit**:

1. Payment In Full: cash, check, or credit (Visa, American Express, MasterCard, or DISC)
2. In House Payment Plans for copays/fees greater than $200: 50% Down Payment + 25% monthly payment on a debit or credit card stored on file in office.
3. Care Credit: Deferred-Interest Monthly Payment Plans *Subject to credit approval

_____ **Returned Check Fee**: A fee of $30.00 will be charged on all returned checks.

_____ **Financial Policy**: 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 and may result in dismissal from our office.

By signing this agreement, the patient agrees with the office of **Brenner Dental Group, 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 by the National Arbitration Forum, under the Code of Procedure then in effect. 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 have read and understand all of the information contained in this form, and sign on behalf of all members of this account.

Signature of **PATIENT**, **PARENT**, or **GUARDIAN**: _____ Date: _____

REQUEST FOR RELEASE OF PATIENT RECORDS

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

_____

Please include any family members who wish to transfer their records as well:

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

I hereby authorize:

Clinic Name: _____

Phone: _____ Fax: _____

City/State: _____

To release any and all requested dental information, including copies of my dental record and radiographs, to:

☐ **Brenner Dental Group**
Buffalo, MN
Phone: 763-682-2101
Fax: 763-682-5069
Email: office@brennerdentalgroupmn.com

☐ **Clinic Name:** _____
City/State: _____
Phone: _____
Fax: _____
Email: _____

Reason for Leaving:

◯ Moving ◯ Insurance is out of network ◯ Hours of Operation ◯ Billing Problem

◯ Other (Please specify): _____

Signature of **PATIENT**, **PARENT** or **GUARDIAN**: _____ Date: _____