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 appreciation 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:

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

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

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:** _____