WELCOME TO OUR PRACTICE!

Please fill out the forms to the best of your ability, anything that has an * by it is required to be filled out.

Patient Registration

*Patient's Full Legal Name: ____________________________________Preferred Name: _______________

*Gender: ◯Male ◯Female *Date of Birth:_____________________ *SSN: ___________________________

Marital Status: ◯Single ◯Married ◯Divorced ◯Widowed

*Address:____________________________*City:___________________*State:_________*Zip:____________

Email Address:____

*Home Phone: ____________________ **OR** *Cell Phone: _________________________

Please use whichever one is best to get a hold of you regarding appointment information.

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:

Insurance Information

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: _____________________________

Medical History

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 ***Are you under a physician's care now? 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?**

◯Aspirin ◯Penicillin ◯Codeine ◯Local Anesthetics ◯Acrylic ◯Metal ◯Latex ◯Sulfa drugs ◯Other: ________________

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

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

◯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 **Taking oral contraceptives?** ◯Yes ◯No **Nursing?** ◯Yes ◯No

***Do you have, or have you had, any of the following?**

Condition	Y/N	Condition	Y/N
AIDS/HIV Positive	Ⓨ Ⓝ	Easily Winded	Ⓨ Ⓝ
Alzheimer's Disease	Ⓨ Ⓝ	Emphysema	Ⓨ Ⓝ
Anaphylaxis	Ⓨ Ⓝ	Epilepsy or Seizures	Ⓨ Ⓝ
Arthritis/Gout	Ⓨ Ⓝ	Excessive Bleeding	Ⓨ Ⓝ
Artificial Heart Valve	Ⓨ Ⓝ	Excessive Thirst	Ⓨ Ⓝ
Artificial Joint	Ⓨ Ⓝ	Fainting Spells/Dizziness	Ⓨ Ⓝ
Asthma	Ⓨ Ⓝ	Frequent Cough	Ⓨ Ⓝ
Blood Disease	Ⓨ Ⓝ	Frequent Diarrhea	Ⓨ Ⓝ
Blood Transfusion	Ⓨ Ⓝ	Frequent Headaches	Ⓨ Ⓝ
Breathing Problem	Ⓨ Ⓝ	Genital Herpes	Ⓨ Ⓝ
Bruise Easily	Ⓨ Ⓝ	Glaucoma	Ⓨ Ⓝ
Cancer	Ⓨ Ⓝ	Hay Fever	Ⓨ Ⓝ
Chemotherapy	Ⓨ Ⓝ	Heart Attack/Failure	Ⓨ Ⓝ
Chest Pains	Ⓨ Ⓝ	Heart Murmur	Ⓨ Ⓝ
Cold Sores/Fever Blisters	Ⓨ Ⓝ	Heart Pacemaker	Ⓨ Ⓝ
Congenital Heart Disorder	Ⓨ Ⓝ	Heart Trouble/Disease	Ⓨ Ⓝ
Convulsions	Ⓨ Ⓝ	Hemophilia	Ⓨ Ⓝ
Cortisone Medicine	Ⓨ Ⓝ	Hepatitis A	Ⓨ Ⓝ
Diabetes	Ⓨ Ⓝ	Hepatitis B or C	Ⓨ Ⓝ
Drug Addiction	Ⓨ Ⓝ	Herpes	Ⓨ Ⓝ

High Blood Pressure	◯Y ◯N	Rheumatic Fever	◯Y ◯N
High Cholesterol	◯Y ◯N	Rheumatism	◯Y ◯N
Hives or Rash	◯Y ◯N	Scarlet Fever	◯Y ◯N
Hypoglycemia	◯Y ◯N	Shingles	◯Y ◯N
Irregular Heartbeat	◯Y ◯N	Sickle Cell Disease	◯Y ◯N
Kidney Problems	◯Y ◯N	Sinus Trouble	◯Y ◯N
Leukemia	◯Y ◯N	Spina Bifida	◯Y ◯N
Liver Disease	◯Y ◯N	Stomach/Intestinal Disease	◯Y ◯N
Low Blood Pressure	◯Y ◯N	Stroke	◯Y ◯N
Lung Disease	◯Y ◯N	Swelling of limbs	◯Y ◯N
Mitral Valve Prolapse	◯Y ◯N	Thyroid Disease	◯Y ◯N
Osteoporosis	◯Y ◯N	Tonsillitis	◯Y ◯N
Pain in Jaw Joints	◯Y ◯N	Tuberculosis	◯Y ◯N
Parathyroid Disease	◯Y ◯N	Tumors or Growths	◯Y ◯N
Psychiatric Care	◯Y ◯N	Ulcers	◯Y ◯N
Radiation Treatments	◯Y ◯N	Venereal Disease	◯Y ◯N
Recent Weight Loss	◯Y ◯N	Yellow Jaundice	◯Y ◯N

Other: (If so, please explain).____

Renal Dialysis ◯Y ◯N

____

***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

◯Yes ◯No Have you ever whitened your teeth before? If yes, how:

◯Yes ◯No Are you interested in learning about whitening options available?

The above information is accurate to the best of my knowledge and **I will** inform my dental office of any changes.

***Patient/Responsible Party Signature:**____

***Date:**____________________________

Office Policies:

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 lifetime. 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 designed 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:

1. Payments in Full on the Date of service – We accept payments via:
   a. Check
   b. Credit card
   c. Cash (only if exact amount)
2. Patient Third Party Financing – We offer patient flexible payment arrangements from Sunbit or CareCredit. Filed on or before the date of service.
3. In-House Payment Plan – Filed on or before date of service. Two types of In-House payment plan options:
   a. Ortho Clear Aligners Payment Plan- Spanning from 6-12 months depending on treatment length
   b. All Other Services Payment Plan
      - We do not carry accounts receivable for more than 60 days.

Initial: __________I consent

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 $88 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. Our time is as valuable as yours and we need adequate timing for your and other patient's appointments. If you are unable to arrive at your scheduled appointment within 5 minutes of your scheduled appointment time, we have the right to cancel and reschedule your appointment. If you are late 3 or more times a fee may be added to your account.

Initial:__________ I consent

By signing this agreement, the patient agrees with the practice 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 the practice 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.

***Patient/Responsible Party Signature:**____

***Date:**___________________________

HIPAA Acknowledgment Form

Patient Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name: ____
Date of Birth: ____

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), we are required to provide you with a copy of our **Notice of Privacy Practices**, which outlines how your medical and dental information may be used and disclosed, and how you can access this information.

Please review the following and sign below to acknowledge receipt.

I acknowledge that I have received, read, or had the opportunity to read a copy of the **Notice of Privacy Practices** for Brenner Dental Group. I understand that this notice explains how my personal health information may be used and disclosed, and how I can gain access to this information.

☐ I have received and reviewed the Notice of Privacy Practices.
☐ I decline a copy but understand I may request one at any time.

Signature of Patient (or Legal Guardian): _______________________________
Printed Name: ____
Date: ___________________________