BROWN ROAD DENTAL
FAMILY DENTISTRY

Registration and Health History

Patient Information

Today's Date: _____ Reason for this visit:_____

Patient's Name: _____ DOB: _____
SS#:_____

Address: _____
City _____ State_____ Zip _____ Home # _____
Work # _____ Cell # _____
DL #_____ Sex: _____ Marital Status: _____
Employer: _____
Email:_____

Person to contact in an emergency _____ Phone # _____
If patient is a minor, give parent or guardian's name _____
How did you hear about our office? _____

Dental Insurance Information

Insured's Name: _____ Relation to patient: _____
Insured's SS#: _____ Insured DOB: _____

Insured's Address (if different than above): _____
City _____ State _____ Zip _____

Insured's Employer:_____ Insurance Company:_____
Claim's Address:_____
Phone #:_____ Group #:_____ Effective Date of Coverage:_____

The information above is true and correct to the best of my belief. I authorize any provider of services to furnish any information requested. I also hereby authorize my Dental Plan Administrator to release or obtain from my organization or person information that may be necessary to determine benefits payable under the group benefits with the Dental Benefit Plan. A Photostat copy of this authorization shall be considered as effective and valid as the original.

Although I have requested the dentist to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure that the bill is paid within 45 days. If for any reason, my insurance company does not pay any portion of my bill, I further agree to make prompt payment of the bill. I understand that I am responsible for all of the charges for all services rendered to me or any member of my family.

I hereby authorize payment directly to the provider of the dental benefits otherwise payable to me.

Signed _____ **Date** _____

855 E Brown Road, Suite 4, Mesa, AZ 85203 (480) 834-6100

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Dental History

Patient Name_____ **Date** _____
Reason for today's visit: _____
Is there anything about your smile you do not like? _____

Are you experiencing any of the following:

___ Bad Breath	___ Broken Teeth	___ Hot Sensitivity	___ Loose Teeth	___ Migraines
___ Bleeding Gums	___ Broken Fillings	___ Sweet Sensitivity	___ TMJ Discomfort	___ Earaches/Neck Pain
___ Sore Gums	___ Tooth Pain	___ Cold Sensitivity	___ Teeth Grinding	___ Snoring

Medical History

Primary Physician's Name: _____Phone # _____
Are you under the care of a specialist (i.e. Cardiologist, etc.)? ___Y ___N Explain:_____
Specialist's Name:_____ Phone # _____
Have you or are you taking any bisphosphonate drug (i.e. Fosamax, Actonel, Boniva)? ___Y ___N

Check any of the following that you have had or presently have:

__ Anemia	__ Hepatitis A B C	__ Heart disease or attack	__ AIDS/HIV
__ Excessive Bleeding	__ Radiation treatment	__ High Blood Pressure	__ Liver disease
__ Emphysema	__ Psychiatric disorder	__ Cardiac Stent	__ Tuberculosis
__ Mitral Valve Prolapse	__ Asthma	__ Congenital heart failure	__ Kidney disease
__ Artificial heart valve	__ Sinus trouble	__ Heart Murmur	__ Heart Pacemaker
__ Drug Dependency	__ Allergies or hives	__ Heart surgery	__ Alcoholism
__ Thyroid disease	__ Blood transfusion	__ Stroke	__ Hemophilia
__ Epilepsy or seizures	__ Osteoporosis	__ Blood thinners (Coumadin)	__ Nervousness/Anxiety
__ Chemotherapy	__ History of Endocarditis	__ Rheumatic Fever	__ Cortisone medicine
__ Fainting	__ Arthritis	__ Cosmetic surgery	__ HPV
__ Artificial joints	__ Fever blisters/Ulcers	__ Tobacco Use	__ Diabetes Type 1/Type 2
__ Pre-Medicate (_____)			

List all medications you are currently taking, including over the counter and dietary or herbal supplements:

_____ _____ _____
_____ _____ _____
_____ _____ _____

List Allergies: _____

Have you ever had a series illness or operation? ___Y ___N Describe:_____

(Woman) Are you pregnant? ___Y ___N If yes, which trimester:_____

Is there any other medical or dental information or experiences that you feel we should know about?

_____
_____

Patient Signature or Parent/Guardian of child: _____
Print Name:_____ **Date:** _____

Doctor's Signature: _____ **Date:** _____

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Financial Policy

We are committed to handling the financial end with you in mind. In order to maintain an ongoing, positive relationship with our patients, we would like to disclose our options for financing procedures for your dental health.

Payment in full is required at the time services are rendered.
Please make sure we have your most current insurance information on file.

For the convenience of our patients, we ask for payment to be made on the day of the appointment. This allows for less confusion and offers the patient to take make financial arrangements in the office.

If you have an insurance plan that our office can accept, we will be glad, as a courtesy, to file to the insurance company for your benefits. We will estimate your copay based on information we obtain from your insurance company. This copay is expected at the time services are rendered. If the insurance company pays less than expected or not at all, we will bill you for the balance. This payment is expected in full upon receipt.

Or, we offer outside financing through Care Credit. It is a credit card that you may apply for. They offer several options for smaller payments and may be used by any member of your family.

Brown Road Dental accepts Visa, MasterCard, and Discover. We can also keep your credit card information securely stored and can automatically run a payment on a designated date. We also welcome your personal checks with proper identification.

The patient is responsible for any fee(s) incurred due to any associated account(s) becoming delinquent. After 90 days, if an account is not paid in full and/or the patient has not contacted our office with a payment plan that is suitable to both parties, your account will be turned over to an outside collection agency. In the event an account is turned over, the patient will be responsible for payment of any collection costs and/or attorney fees, in addition to the balance owed.

We thank you for your cooperation in our financial policy. We are dedicated to your oral health and will help you in any way we can.

Signature: _____ **Date:** _____

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Notice of Privacy Practices: Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

I have been given the opportunity to receive Brown Road Dental's Notice of Privacy Practices. I understand that this notice is Federally mandated and that it provides in detail the uses and disclosures of my protected health information that may be made by Brown Road Dental, my individual rights and Brown Road Dental's legal duties with respect to my protected health information. These include, but are not limited to the following:

- A statement that Brown Road Dental is required by law to maintain the privacy of protected health information.
- A statement that they are required to follow the terms of the notice currently in effect.
- Types of uses and disclosures that can be made for each of the following purposes: Treatment, Payment, and Health Care Operations.
- A description of other situations where disclosure of protected health information is permitted or required without my consent or authorization.
- A description of uses and disclosures that are prohibited or limited by law.
- A description of disclosures that require my written authorization and how I may revoke authorizations.
- My individual rights with respect to protected health information and how I can exercise those rights
- The right to complain to Brown Road Dental and to the Secretary of HHS if my privacy rights have been violated and that no retaliatory actions will be taken because of such a complaint.
- The right to request restrictions of certain uses and disclosures of my protected health. However, I understand Brown Road Dental does not have to agree to honor my requested restrictions.
- The right to receive confidential communications of protected health information
- The limited right to inspect and copy certain protected health information.
- The right to request to amend protected health information.
- The right to request an accounting of disclosures of protected health information.
- The right to obtain a paper copy of the Notice of Privacy Practices from Brown Road Dental upon request.

I also understand Brown Road Dental reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions for all protected health information that it maintains. Furthermore, if changes are made, I can obtain a revised Notice of Privacy Information upon request.

Signature: _____ **Date:** _____

Relationship to Patient {if signed by a personal representative of patient} _____

IF you would like to authorize a person or persons to be able to talk about your treatment or account, please sign below. My treatment and account status may be discussed with _____

_____ Date: _____
(Relationship)