Brookhaven Dental Center

Thank You for Selecting Our Dental Team! To help us meet all your healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us and we will be happy to help you. Please return this to the front desk as soon as possible so that you will be seen in a timely manner.

PATIENT INFORMATION

Date _____

Name _____

Address _____

_____
City/State Zip

Email _____

Home #_____ Work #_____ Cell # _____

Birth Date_____ SS# _____

Employer Name _____

Married_____ Single_____ Student_____ if student, name school_____

Spouse/Guardian Name _____

Spouse/Guardian Home #_____Cell # _____

Spouse/Guardian SS# _____ Birth Date _____

Spouse/Guardian Employer _____

RESPONSIBLE PARTY

Please note: Payment is due the day services are rendered. There is no in office payment plan. We have several payment plans available. Ask our staff for details. Please take care of these issues beforehand. If the patient is a minor child, the person with the child is responsible for payment.

Name of person responsible for this account _____

Address_____

_____

Home Phone/Cell _____

SS#_____ Date of Birth _____

Employer _____

INSURANCE INFORMATION (if different from responsible party)

We will be glad to file your insurance claims for you, please be aware that anything not covered by your insurance will be your responsibility.

Name of Policy Holder _____
SS# or ID # _____ Policy Holder Date of Birth _____
Employer _____ Insurance Carrier_____
Do you have any additional dental insurance? Y / N If yes, please give information to front desk.

--OVER--

MEDICAL HISTORY

It is extremely important to fill this portion out as accurately as possible.

Are you under any medical treatment now? Yes_____ No_____
If yes, Physicians Name_____

Have you been hospitalized within the last 5 years? Yes_____ No_____
If yes, please explain _____

Are you taking any medications? Yes_____ No_____
If yes, please list _____

Have you ever taken Fosamax, Boniva, Actonel or any medications with bisphosphonates? Yes_____ No_____

Have you taken Viagra, Revatio, Cialis or Levitra within the last 24 hours? Yes_____ No_____

Do you use tobacco? Yes_____ No_____

Are you allergic to or have had a reaction to any of the following:

Local Anesthetics (e.g. Novocain) Yes_____ No_____

Penicillin or any other Antibiotics Yes_____ No_____

Latex Rubber Yes_____ No_____

Any other allergies not listed? Yes_____ No_____
If yes please list _____

Women only:

Are your pregnant or think you may be pregnant? Yes_____ No_____
Are you nursing? Yes_____ No_____
Are you taking oral contraceptives? Yes_____ No_____

Have you had any of the following:

	Yes	No		Yes	No
High Blood Pressure			Tuberculosis		
Low Blood Pressure			Asthma		
Heart Attack			Epilepsy		
Heart Disease			Diabetes		
Pacemaker			Cancer		
Heart Problems/Chest Pains			Radiation Therapy		
Stints			Anemia		
Mitral Valve Prolapse			Hepatitis/Jaundice		
Blood Thinner			Liver Disease		
Joint Replacement			AIDS/HIV		
Stroke			Thyroid Problems		

Do you take an Aspirin daily? If so what milligram _____

PATIENT DENTAL HISTORY

Date of last dental visit _____

Date of last dental x-ray _____

Have you had any problems in the past with any dental procedures?
If yes please explain _____

Do you currently wear dentures or partials?	Yes_____ No_____
Do your gums bleed while brushing or flossing?	Yes_____ No_____
Are your teeth sensitive to hot or cold liquids or foods?	Yes_____ No_____
Do you feel pain in any of your teeth?	Yes_____ No_____
Have you had any head, neck or jaw injuries?	Yes_____ No_____
Do you have frequent headaches?	Yes_____ No_____
Do you clench or grind your teeth?	Yes_____ No_____
Have you ever had any difficult extractions in the past?	Yes_____ No_____
Have you ever had any prolonged bleeding after an extraction?	Yes_____ No_____
Have you ever received oral hygiene instructions about the care of your teeth and gums?	Yes_____ No_____
Do you like your smile?	Yes_____ No_____

Whom may we thank for referring you?

_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ Date _____

Signature of Patient (or parent/guardian if minor)

If signed by patient representative, state relationship to patient _____

Notice of Privacy Practices

I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews. I have been informed that I may review the practices Notice of Privacy Practices before signing this consent. I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices from the practice. I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restrictions. I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

_____ Date _____

Signature of Patient (or parent/guardian if minor)

If signed by patient representative, state relationship to patient _____