

NEW PATIENT FORMS

New Patients

Welcome to our practice. Our Primary purpose is to serve you and your family, to provide for your dental health needs in a considerate and caring fashion. For your protection has the most modern equipment, the latest techniques, above all, we follow OSHA guidelines in advanced sterilization technology for both staff and patient protection.

Consent for Services

As a Condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their case. Financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, and any dental services performed without previous financial arrangements, must be paid in full at time services are preformed. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the examination.

Medical and Dental Authorization

I have read the information on the health questionnaire and it is accurate to the best of my knowledge. I understand that the dentist to help determine appropriate and helpful dental treatment will use this information provided. If there are any changes in my medical status, I will inform the dentist.

Insurance Authorization

If you have dental insurance, we will gladly process your claims. We do request that you provide us with the most current, accurate insurance information on the subscriber of the policy. **All patients are expected to pay any applicable co-payments prior to leaving our office.** We are happy to submit your claims but please remember that **our contract is with you and not your insurance company.** Any claims that are outstanding past 45 days will become the patients' responsibility. PLEASE remember that the treatment plans presented are ESTIMATES, not GUARANTEES of payment. We do the best we can in getting benefits from insurance companies but please remember that the information received over the phone is an ESTIMATE.

_____ (initials) I have read and understand the above insurance policies.

Cancelled/Missed Appointments

We reserve the right to charge \$40.00 for appointments cancelled or missed without 24hrs-advanced notice.

I have read and understand this policy. _____ (initials)

Payment Options

Payment is due at the time of treatment. We accept cash, check and all major credit cards. We also have a no interest payment plan, Care Credit. Care Credit allows you to start treatment today and spread payments over time. Applying for Care Credit takes only a few minutes and there is no fee to apply. Just remember, anytime you apply for any type of medical or dental financing, it will not affect your credit score.

I HAVE READ THE ABOVE CONDITIONS OF TREATMENT AND AGREE TO THEIR CONTENT.

Signature of patient, parent or guardian

Date _____

BRANNON DENTAL GROUP

21809 N. Scottsdale Rd., C-105 Scottsdale, AZ 85255
480-563-0000 ph. 480-563-4445 fax. www.BrannonDental.com

PATIENT INFORMATION FORM

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc. Sec.# _____

Last Name *First Name* *Initial*

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Work Phone _____

Email _____

Primary Insurance

Person Responsible for Account _____

Last Name *First Name* *Initial*

Relation to Patient _____ Birth date _____ Soc. Sec. # _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber# _____

Name of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? Yes No

Subscriber Name _____ Relation to Patient _____ Birth date _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Dental History

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

Check Y box for Yes or the N box for No if you have had problems with any of the following:

- | | | |
|---|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Bad Breath | <input type="checkbox"/> Y <input type="checkbox"/> N Grinding or clenching teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to hot |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding Gums | <input type="checkbox"/> Y <input type="checkbox"/> N Loose teeth or broken fillings | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to sweets |
| <input type="checkbox"/> Y <input type="checkbox"/> N Clicking or popping jaw | <input type="checkbox"/> Y <input type="checkbox"/> N Periodontal treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity when biting |
| <input type="checkbox"/> Y <input type="checkbox"/> N Food collection between teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to cold | <input type="checkbox"/> Y <input type="checkbox"/> N Sores or growth in mouth |

How often do you brush? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?

Y N

Other information about your dental health or previous treatment _____

Medical History

Physician's name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? Y N

If yes, describe _____

Are you currently under physician care? Y N If yes, describe _____

Have you ever had a blood transfusion? Y N If yes, give approximate dates _____

Have you ever taken FenPhen/Redux? Y N

Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Check Y box for Yes or the N box for No whether you have had any of the following:

- | | | |
|---|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive | <input type="checkbox"/> Y <input type="checkbox"/> N Food allergies | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation treatment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anaphylaxis | <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Respiratory disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis, Rheumatism | <input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial heart valves | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Problems | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial joints | Describe _____ | <input type="checkbox"/> Y <input type="checkbox"/> N Skin rash |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/Abnormal bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Spina Bifida |
| <input type="checkbox"/> Y <input type="checkbox"/> N Atopic (allergy prone) | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Back problems | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N Surgical implant |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood Disease | <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure | <input type="checkbox"/> Y <input type="checkbox"/> N Swelling of feet and ankles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N Jaw pain | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease or malfunction |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemical dependency | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney disease or malfunction | <input type="checkbox"/> Y <input type="checkbox"/> N Tobacco habit |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N Liver disease | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Circulation Problems | <input type="checkbox"/> Y <input type="checkbox"/> N Material allergies | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cortisone treatments | (latex, wood, metal, chemicals) | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcer/Colitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cough persistent | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral valve prolapse | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cough up blood | <input type="checkbox"/> Y <input type="checkbox"/> N Nervous problems | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker/Heart surgery | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric care | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fainting | <input type="checkbox"/> Y <input type="checkbox"/> N Rapid weight gain or loss | |

Is patient currently taking any medications? If yes, list all: _____ Does patient have drug allergies? If yes, list all: _____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Print Name _____ Signature _____

Date Signed _____ Pt. DOB _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

NOTICE OF PRIVACY PRACTICES

Brannon Dental Group
21809 N Scottsdale Rd. C-105
Scottsdale, AZ. 85255

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our **Commitment** here at the **Brannon Dental Group** is to serve our patients with professionalism and caring, being sure at all times the **PROTECT** the privacy and security of all Protected Health Information.

During the course of serving your interests, it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared:

- During Treatment, we may find it necessary to consult with a dental laboratory.
- For payment purposes, we may use the services of a billing service.
- During dental care, we may need to consult with your physician or previous dentist.
- For payment purposes, we may need to supply information requested from your dental insurance company.

We here at the Brannon Dental Group are committed to obeying Federal, State and Local Laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with written authorization of the individual in question. The individual, as provided by law, may revoke this written authorization at any time.

If you have any questions or comments regarding your Protected Health Information, feel free to call with any questions.

I have read and understand the above Notice of Privacy Practices.

Signed: _____ Date: ____ / ____ / ____