BROOKSIDE FAMILY DENTISTRY

About You

Date: ______________

Name:_______________________________

Birthdate: ___ /___ /___

SSN:___________________

Home Address:___________________________________

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Home #: (____)_________________

Cell #: (____)___________________

E-mail: ____

Previous dentist:_______________________________

Reason for switching dentist:___________________________

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Dental History

Reason for visit:_______________________________________

What is your primary concern that you would like us to address first?

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What do you value MOST in a dental office?

Please write answer below

Cosmetic-You most value how your teeth look. Want them straighter. Want them whiter.

Function-You most value your ability to enjoy your favorite foods. Don't want to be limited to just eating on one side or area.

Comfort- You most value NOT being in pain or having any tooth or gum sensitivities.

Longevity-You most value the ability to have your teeth forever. You wish to have any work last as long as possible

Cost- You most value keeping treatment costs down. You only want to do what the insurance will pay for.

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Welcome

How did you hear about our office? **Check all that apply**

- ☐ Google
- ☐ Facebook
- ☐ Postcard
- ☐ Magazine
- ☐ Friend: ______________________
- ☐ Other: ______________________

Emergency Contact

Name: ____

Primary Phone: (____)____________________________

Relationship: ___________________________________

MEDICAL HISTORY

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription drugs? ☐ Yes ☐ No

Please list each one: ____________________________________

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Are you Pregnant or Nursing:____________________________

Have you ever taken Bisphosphonates? (ex. Fosamax, Boniva)

☐ Yes ☐ No If so, when: _________________________

Have you ever had any of the following diseases or medical problems:

Y	N	Abnormal Bleeding	Y	N	HIV+ / AIDS
Y	N	Alcohol / Drug Abuse	Y	N	Hospitalized ever
Y	N	Anemia	Y	N	Kidney Problems
Y	N	Artificial bones/Joints/Valves	Y	N	Liver Disease
Y	N	Asthma	Y	N	Low Blood Pressure
Y	N	Blood Transfusion	Y	N	Lupus
Y	N	Cancer / Chemotherapy	Y	N	Pacemaker
Y	N	Congenital Heart Defect	Y	N	Psychiatric Problems
Y	N	Diabetes	Y	N	Radiation Treatment
Y	N	Epilepsy	Y	N	Rheumatic/Scarlet Fever
Y	N	Fainting Spells	Y	N	Seizures
Y	N	Heart Attack	Y	N	Sickle Cell Disease/Traits
Y	N	Heart Surgery	Y	N	Sinus Problems
Y	N	Hemophilia	Y	N	Stroke
Y	N	Hepatitis	Y	N	Thyroid Problems
Y	N	High Blood Pressure	Y	N	Tuberculosis (TB)

Please list any medical condition(s) that you have ever had:

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MEDICAL HISTORY (CONT.)

Do you have a primary care physician? ☐ Yes ☐ No

Physician's Name: ____________________________________

Phone #: (___)________________ Date of last visit: __________

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin
Y	N	Codeine	Y	N	Penicillin
Y	N	Dental Anesthetics	Y	N	Clindamycin
Y	N	Latex	Y	N	Other

Please list any other drugs/materials that you are allergic to:

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We would like to welcome you and your family to our dental practice.

Please take the time to review some of our office policies:

1. 24 hours notice must be given to cancel an appointment; a no-show fee of $50.00 will be charged if notice is not given.
2. Payment for services are due at the time services are rendered.
3. Patients must keep our office informed of insurance changes as well as address and phone number changes.

YOUR INSURANCE BENEFITS ARE NOT DETERMINED BY THIS OFFICE

The percentage that insurance pays is determined by the type of group insurance plan you or your employer purchases. We can in no way alter the policy or guarantee your payments. To avoid disappointment, we strongly suggest that you contact your insurance company to learn exactly what your policy provides.

Our dental services are rendered to you, not the insurance company. Therefore, you are personally and directly responsible for the obligation of payment fees.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

____ ______________________

Signature **Date**

NOTICE OF PRIVACY PRACTICES (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU/OR YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY.

Keeping your health information confidential and secure and using it only as permitted by law is a top priority of this office. You have the right to know how our office uses and discloses your health information. Under the Health Insurance Portability and Accountability Act (HIPAA), Brookside Family Dentistry PLLC can use your health information for Treatment, Payment and Health Care Operations. In connection with “Treatment”, we may use or disclose your health information to other dentists or health care providers who may be treating you. In connection with “Payment”, we may use and disclose your health information to facilitate payment by health insurers. In connection with “Health Care Operations”, we may use and disclose your health information to facilitate our business operations. We may also contact you by telephone to remind you of appointments and call you by name when the doctor is ready to see you. Certain uses and disclosures that do not fall under Treatment, Payment or Health Care Operations will require your written authorization. For example, if you would like us to send information to an employer, your written authorization may be required. We value our patients and the various rights afforded to them under federal and state law to access health information. To that end, we recognize and will accommodate patients’ rights to restrict the disclosure of health information, if we agree to such a restriction. We will also accommodate patients’ rights to receive confidential communication of their health information and this notice. We look forward to providing quality service to you and to ensuring that your health information remains confidential.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

Signature___________________________________ Date ________________________

Turn Over →

BROOKSIDE
FAMILY DENTISTRY

CONSENT FORM FOR GENERAL DENTAL PROCEDURES

You the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre- and post-treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

If you are a woman on oral birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

As with all healthcare treatment, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly known risks and complications of treatment include, but are not limited to the following: Pain, swelling and discomfort after treatment, infection in need of medication, follow-up procedures or other treatment. Temporary, or on rare occasion, permanent numbness, pain, tingling, or altered sensation of the lip, face, chin, gums and tongue along with possible loss of taste. Damage to adjacent teeth, restorations or gums. Allergic reaction to anesthetic or medication. Need for follow-up treatment with a specialist, including surgery.

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

Signature___________________________________ Date ________________________

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