MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems you may have, or medication that you may be taking, could have an important interrelationship 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?

AIDS/HIV Positive	Y◯ N◯	Fainting Spells/Dizziness	Y◯ N◯	Mitral Valve Prolapse	Y◯ N◯
Alzheimer's Disease	Y◯ N◯	Frequent Cough	Y◯ N◯	Osteoporosis	Y◯ N◯
Anaphylaxis	Y◯ N◯	Frequent Diarrhea	Y◯ N◯	Pain in Jaw Joints	Y◯ N◯
Arthritis/Gout	Y◯ N◯	Frequent Headaches	Y◯ N◯	Parathyroid Disease	Y◯ N◯
Artificial Heart Valve	Y◯ N◯	Genital Herpes	Y◯ N◯	Psychiatric Care	Y◯ N◯
Artificial Joint	Y◯ N◯	Glaucoma	Y◯ N◯	Radiation Treatments	Y◯ N◯
Asthma	Y◯ N◯	Hay Fever	Y◯ N◯	Recent Weight Loss	Y◯ N◯
Blood Disease	Y◯ N◯	Heart Attack/Failure	Y◯ N◯	Renal Dialysis	Y◯ N◯
Blood Transfusion	Y◯ N◯	Heart Murmur	Y◯ N◯	Rheumatic Fever	Y◯ N◯
Breathing Problem	Y◯ N◯	Heart Pacemaker	Y◯ N◯	Rheumatism	Y◯ N◯
Bruise Easily	Y◯ N◯	Heart Trouble/Disease	Y◯ N◯	Scarlet Fever	Y◯ N◯
Cancer	Y◯ N◯	Hemophilia	Y◯ N◯	Shingles	Y◯ N◯
Chemotherapy	Y◯ N◯	Hepatitis A	Y◯ N◯	Sickle Cell Disease	Y◯ N◯
Chest Pains	Y◯ N◯	Hepatitis B or C	Y◯ N◯	Sinus Trouble	Y◯ N◯
Cold Sores/Fever Blisters	Y◯ N◯	Herpes	Y◯ N◯	Spina Bifida	Y◯ N◯
Congenital Heart Disorder	Y◯ N◯	High Blood Pressure	Y◯ N◯	Stomach/Intestinal Disease	Y◯ N◯
Convulsions	Y◯ N◯	High Cholesterol	Y◯ N◯	Stroke	Y◯ N◯
Cortisone Medicine	Y◯ N◯	Hives or Rash	Y◯ N◯	Swelling of limbs	Y◯ N◯
Diabetes	Y◯ N◯	Hypoglycemia	Y◯ N◯	Thyroid Disease	Y◯ N◯
Drug Addiction	Y◯ N◯	Irregular Heartbeat	Y◯ N◯	Tonsillitis	Y◯ N◯
Easily Winded	Y◯ N◯	Kidney Problems	Y◯ N◯	Tuberculosis	Y◯ N◯
Emphysema	Y◯ N◯	Leukemia	Y◯ N◯	Tumors or Growths	Y◯ N◯
Epilepsy or Seizures	Y◯ N◯	Liver Disease	Y◯ N◯	Ulcers	Y◯ N◯
Excessive Bleeding	Y◯ N◯	Low Blood Pressure	Y◯ N◯	Venereal Disease	Y◯ N◯
Excessive Thirst	Y◯ N◯	Lung Disease	Y◯ N◯	Yellow Jaundice	Y◯ N◯

Have you ever had any serious illness not listed above? Yes ◯ No ◯ If yes, please explain: _____

_____

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

Emergency Contact Name: _____ Phone: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of **PATIENT**, **PARENT**, or **GUARDIAN**: _____ Date: _____

ABOUT YOU

Patient's Full Name: _____

Preferred Name: _____

Date of Birth: _____

Gender: ◯ Male ◯ Female

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Home Phone: _____Cell Phone: _____

Responsible Party's Name (if different from above): _____

How did you hear about our clinic? _____

Primary Dental Insurance

Policy Holder: _____

Date of Birth: _____

Employer/Group Name: _____

Group Number: _____

Insurance Company: _____

Member ID or SSN: _____

Sec Primary Dental Insurance

Policy Holder: _____

Date of Birth: _____

Employer/Group Name: _____

Group Number: _____

Insurance Company: _____

Member ID or SSN: _____

Cancellation Policy:

When you schedule an appointment, we prepare in anticipation of serving you. If you need to reschedule, **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 $75 charge.

INITIALS: _____

HIPAA Privacy Acknowledgement and Financial Statement

I understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement; this facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

INITIALS: _____

I agree to pay fees and expenses incurred by Corey J. Brenner, DDS, PLLC 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.

INITIALS: _____

By signing this agreement, the patient agrees with the office of Corey J. Brenner, DDS PLLC 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.

Signature of **PATIENT, PARENT, or GUARDIAN**: _____ Date: _____