

WELCOME!

Patient's Full Name: _____ Preferred Name: _____

Gender: M F Date of Birth: _____ Marital Status: Single Married Divorced Widowed

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

Email Address: _____ SSN: _____

Home Phone: _____ Cell Phone: _____

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

Emergency Contact: _____ Phone: _____

How did you hear about our clinic? Drive-by Internet Search Family/Friend: _____

Other: _____

Primary Dental Insurance	Primary Dental Insurance
Policy Holder: _____	Policy Holder: _____
Date of Birth: _____	Date of Birth: _____
Employer/Group Name: _____	Employer/Group Name: _____
Group Number: _____	Group Number: _____
Insurance Company: _____	Insurance Company: _____
Member ID or SSN: _____	Member ID or SSN: _____

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.

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.

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.

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.



Patient/Responsible Party Signature: _____ **Date:** _____

Although dental personnel primarily treat the area in/around your mouth, your mouth is a part of your entire body. Health problems you have, or medication that you take, could have an important relationship 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 <input type="radio"/> N <input type="radio"/> | Fainting Spells/Dizziness | Y <input type="radio"/> N <input type="radio"/> | Mitral Valve Prolapse | Y <input type="radio"/> N <input type="radio"/> |
| Alzheimer's Disease | Y <input type="radio"/> N <input type="radio"/> | Frequent Cough | Y <input type="radio"/> N <input type="radio"/> | Osteoporosis | Y <input type="radio"/> N <input type="radio"/> |
| Anaphylaxis | Y <input type="radio"/> N <input type="radio"/> | Frequent Diarrhea | Y <input type="radio"/> N <input type="radio"/> | Pain in Jaw Joints | Y <input type="radio"/> N <input type="radio"/> |
| Arthritis/Gout | Y <input type="radio"/> N <input type="radio"/> | Frequent Headaches | Y <input type="radio"/> N <input type="radio"/> | Parathyroid Disease | Y <input type="radio"/> N <input type="radio"/> |
| Artificial Heart Valve | Y <input type="radio"/> N <input type="radio"/> | Genital Herpes | Y <input type="radio"/> N <input type="radio"/> | Psychiatric Care | Y <input type="radio"/> N <input type="radio"/> |
| Artificial Joint | Y <input type="radio"/> N <input type="radio"/> | Glaucoma | Y <input type="radio"/> N <input type="radio"/> | Radiation Treatments | Y <input type="radio"/> N <input type="radio"/> |
| Asthma | Y <input type="radio"/> N <input type="radio"/> | Hay Fever | Y <input type="radio"/> N <input type="radio"/> | Recent Weight Loss | Y <input type="radio"/> N <input type="radio"/> |
| Blood Disease | Y <input type="radio"/> N <input type="radio"/> | Heart Attack/Failure | Y <input type="radio"/> N <input type="radio"/> | Renal Dialysis | Y <input type="radio"/> N <input type="radio"/> |
| Blood Transfusion | Y <input type="radio"/> N <input type="radio"/> | Heart Murmur | Y <input type="radio"/> N <input type="radio"/> | Rheumatic Fever | Y <input type="radio"/> N <input type="radio"/> |
| Breathing Problem | Y <input type="radio"/> N <input type="radio"/> | Heart Pacemaker | Y <input type="radio"/> N <input type="radio"/> | Rheumatism | Y <input type="radio"/> N <input type="radio"/> |
| Bruise Easily | Y <input type="radio"/> N <input type="radio"/> | Heart Trouble/Disease | Y <input type="radio"/> N <input type="radio"/> | Scarlet Fever | Y <input type="radio"/> N <input type="radio"/> |
| Cancer | Y <input type="radio"/> N <input type="radio"/> | Hemophilia | Y <input type="radio"/> N <input type="radio"/> | Shingles | Y <input type="radio"/> N <input type="radio"/> |
| Chemotherapy | Y <input type="radio"/> N <input type="radio"/> | Hepatitis A | Y <input type="radio"/> N <input type="radio"/> | Sickle Cell Disease | Y <input type="radio"/> N <input type="radio"/> |
| Chest Pains | Y <input type="radio"/> N <input type="radio"/> | Hepatitis B or C | Y <input type="radio"/> N <input type="radio"/> | Sinus Trouble | Y <input type="radio"/> N <input type="radio"/> |
| Cold Sores/Fever Blisters | Y <input type="radio"/> N <input type="radio"/> | Herpes | Y <input type="radio"/> N <input type="radio"/> | Spina Bifida | Y <input type="radio"/> N <input type="radio"/> |
| Congenital Heart Disorder | Y <input type="radio"/> N <input type="radio"/> | High Blood Pressure | Y <input type="radio"/> N <input type="radio"/> | Stomach/Intestinal Disease | Y <input type="radio"/> N <input type="radio"/> |
| Convulsions | Y <input type="radio"/> N <input type="radio"/> | High Cholesterol | Y <input type="radio"/> N <input type="radio"/> | Stroke | Y <input type="radio"/> N <input type="radio"/> |
| Cortisone Medicine | Y <input type="radio"/> N <input type="radio"/> | Hives or Rash | Y <input type="radio"/> N <input type="radio"/> | Swelling of limbs | Y <input type="radio"/> N <input type="radio"/> |
| Diabetes | Y <input type="radio"/> N <input type="radio"/> | Hypoglycemia | Y <input type="radio"/> N <input type="radio"/> | Thyroid Disease | Y <input type="radio"/> N <input type="radio"/> |
| Drug Addiction | Y <input type="radio"/> N <input type="radio"/> | Irregular Heartbeat | Y <input type="radio"/> N <input type="radio"/> | Tonsillitis | Y <input type="radio"/> N <input type="radio"/> |
| Easily Winded | Y <input type="radio"/> N <input type="radio"/> | Kidney Problems | Y <input type="radio"/> N <input type="radio"/> | Tuberculosis | Y <input type="radio"/> N <input type="radio"/> |
| Emphysema | Y <input type="radio"/> N <input type="radio"/> | Leukemia | Y <input type="radio"/> N <input type="radio"/> | Tumors or Growths | Y <input type="radio"/> N <input type="radio"/> |
| Epilepsy or Seizures | Y <input type="radio"/> N <input type="radio"/> | Liver Disease | Y <input type="radio"/> N <input type="radio"/> | Ulcers | Y <input type="radio"/> N <input type="radio"/> |
| Excessive Bleeding | Y <input type="radio"/> N <input type="radio"/> | Low Blood Pressure | Y <input type="radio"/> N <input type="radio"/> | Venereal Disease | Y <input type="radio"/> N <input type="radio"/> |
| Excessive Thirst | Y <input type="radio"/> N <input type="radio"/> | Lung Disease | Y <input type="radio"/> N <input type="radio"/> | Yellow Jaundice | Y <input type="radio"/> N <input type="radio"/> |
- Other: _____

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

Yes No Have you ever whitened your teeth before? If yes, how: _____

Yes No Are you interested in learning about whitening options available?

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.

Patient/Responsible Party Signature: _____ Date: _____