

Stuart M. Brown, D.D.S., P.A.**Family Dentistry****Health History and Registration**

Date: ____/____/____

Patient's Name: _____ Sex: M / F

Birth date: ____/____/____ Marital Status: Single Married Separated Divorced Widowed

Patient's Address: _____

City, State, Zip Code: _____

Home Phone #: (____) _____ - _____

Cell Phone #: (____) _____ - _____

Email Address: _____ Work Phone #: (____) _____ - _____

Social Security #: _____ - _____ - _____

Driver's License #: _____

Employer: _____

Occupation: _____

Employer Address: _____

City, State, Zip: _____

Work Phone #: (____) _____ - _____

School Attending (if applicable): _____

Please indicate who referred you to our office: _____

Spouse/Guardian Name: _____

Relation to Patient: _____

Spouse/Guardian Social Security #: _____ - _____ - _____

Cell Phone #: (____) _____ - _____

Spouse/Guardian Employer: _____

Occupation: _____

Spouse/Guardian Employer Address: _____

City, State, Zip: _____

Work Phone #: (____) _____ - _____

Emergency Contact – Please provide the Name, Address, and Phone # of an emergency contact:

Billing Information – Please indicate the person financially responsible for this account (if other than patient):

Name: _____

Relation to Patient: _____

Address: _____

City, State, Zip: _____

Home Phone #: (____) _____ - _____

Cell Phone #: (____) _____ - _____

Work Phone #: (____) _____ - _____

Social Security #: _____ - _____ - _____

Employer: _____

Financial Institution: _____

Medical History

Please indicate any health conditions you have or have had: _____

Name of Physician: _____ **Phone #:** (____) _____ - _____

List ANY MEDICATIONS, including non-prescription drugs, or herbal supplements you take:

Please circle any of the conditions that apply to you:

- | | | | |
|----------------------|------------------------|----------------|-------------------|
| Heart Disease | Artificial Heart Valve | Liver Disease | Tuberculosis |
| Heart Attack | Stroke | Hepatitis | Venereal Disease |
| Angina (chest pains) | Bleeding Disorder | Ulcers | Bruise Easily |
| Heart Murmur | Anemia | Epilepsy | Diabetes |
| Heart Defect | Hemophilia | Seizures | Thyroid Disease |
| Heart Surgery | Artificial Joints | Drug Addiction | Allergies |
| Heart Pacemaker | AIDS / HIV | Alcoholism | Frequent Cough |
| Heart Failure | Psychiatric Treatment | Cancer | Sinus Trouble |
| High Blood Pressure | Blood Transfusion | Emphysema | Arthritis |
| High Cholesterol | Kidney Problems | Asthma | Steroid Treatment |

Do you take antibiotics prior to Dental Treatment? If so, please list: _____

Are you allergic or have you had any bad reactions to any of the following:

Aspirin (Nsaids, Motrin, Etc.): _____

Local Anesthetics: _____

Codeine or Other Narcotics: _____

Antibiotics (please name): _____

Other (please name): _____

Are you pregnant? Possibly pregnant? Do you take birth control pills? _____

Other important medical information: _____

STUART M. BROWN, DDS, PA FAMILY DENTISTRY**Dental History**When was your last *complete* dental exam? _____

When did you last have a full X-Ray Series or Panorex taken? _____

Please circle any of the following dental concerns you may have:

Aesthetics / Appearance
Headaches
Grinding
SensitivityToothaches
Discoloration
Tooth Replacements
Fit of DenturesLoose Teeth
Bleeding Gums
Oral Ulcerations
Herpes / Cold Sores

Are you currently experiencing any dental problems (please explain)? _____

Name of Previous Dentist: _____ Phone #: (____) _____ - _____

Insurance Information

Name of Insured: _____

Social Security #: _____ - _____ - _____ Employer: _____

Insurance Company Name and Address: _____

Secondary Insurance Information (if applicable)

Name of Insured: _____

Social Security #: _____ - _____ - _____ Employer: _____

Insurance Company Name and Address: _____

DENTAL INSURANCE IS A CONTRACT BETWEEN THE INSURANCE CARRIER AND THE INSURED, NOT THE DENTIST. THE PATIENT / RESPONSIBLE PERSON IS LIABLE FOR ALL DENTAL FEES. INSURANCE BENEFIT ESTIMATES ARE ONLY GUIDELINES UNTIL INSURANCE CARRIER HAS PAID.

STUART M. BROWN, DDS, PA**FAMILY DENTISTRY****Consent:**

The undersigned hereby authorizes the Doctor to take x-rays, study models, photographs, medical and dental records, and any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I hereby authorize Dr. Brown and his staff to speak with any health care practitioner who has treated or is currently treating me and/or my dependent(s) about my past or present medical or dental diagnosis, condition, or treatment. This authorization includes the release of my dental or medical records to Dr. Brown as he reasonably deems necessary and remains valid until revoked by me, in writing. I authorize Dr. Brown and staff to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by Dr. Brown or his designees and mutually agreed upon by me. I accept the financial agreement outlined below, as well.

Financial Agreement:

I agree to be responsible for payment of all services rendered on the behalf of my dependents and of myself. I agree that any claims the insurance carrier does not pay within thirty (30) days from the date of treatment are my responsibility to pay and that a finance charge of 1.5% per month may be assessed. I assign all dental benefits to which I am entitled under my insurance plan (if any) to Dr. Brown. I also authorize this office to submit insurance claim forms and receive payment directly from the insurance carrier with the notation, "SIGNATURE ON FILE." I authorize Dr. Brown to release treatment records, X-Rays, and any other information deemed necessary and requested by my insurance carrier. I agree to pay reasonable collection fees and/or attorney's fees and court costs that may be incurred if such services are required by Dr. Brown to collect any balance that I owe him.

I understand and agree that I may be charge for repeatedly breaking or missing appointments without notifying the office at least 24 hours in advance, at the rate of **\$155 per hour** to cover the operating expenses of the office. This fee is not covered by any insurance plan.

Preferred payment method: _____ Payment in Full by Cash or Check
 _____ Payment in Full by Major Credit Card (see agreement)
 _____ Insurance Co-Payment in Full at Time of Visit
 _____ Prearranged Financial Agreement Made with Office

Patient's Signature (guardian, if minor): _____ (SEAL) Date: _____

Spouse's Signature: _____ (SEAL) Date: _____

Dentist's Signature: _____ (SEAL) Date: _____