BRANNON WALDMAN DENTAL GROUP

Name_____ Preferred Name_____

Address_____ Birth Date_____

City_____ State_____ Zip Code _____ SSN_____

Home Phone_____ Cell_____ Work_____

Email _____

Gender: Male Female Marital Status: Married Single Divorced Separated Widowed

Who may we thank for referring you to our office? _____

Emergency Contact: Name _____ Phone _____

Responsible Party Information (If someone other than patient)

Name_____

Address _____Birth Date _____

City, State, Zip _____ SSN _____

Home Phone _____ Cell _____ Work _____

Relationship to Patient _____

We ask that you please notify us at least 48 hours in advance if needing to change or cancel any appointments- or a $40.00 charge will be assessed to your account

Insurance Information

Name or Primary Insured_____ Relationship to Patient _____

Insured SSN or Alternate ID# _____ Insured Birth Date _____

Name of Insurance Company _____ Employer _____

Address _____

City, State, Zip _____

Phone _____

Medical History

Name _____ Date _____

Are you under physician's care now? Yes No If yes, please explain _____

Have you been hospitalized or had a major operation? Yes No If yes, please explain _____

Are you taking any medications? Yes No If yes, please list _____

_____

Women: Are you

Pregnant/trying to get pregnant _____ Nursing _____

Taking contraceptives? _____

Are you allergic to any of the following?

____ Aspirin ____ Penicillin ____ Codeine ____ Acrylic ____ Latex ____ Local Anesthetics

Other _____

Do you have, or have you had, any of the following?

_____ AIDS/HIV Positive
_____Anemia
_____Arthritis, Rheumatism
_____Artificial Heart Valves
_____Artificial Joints
_____Asthma
_____Back Problems
_____Blood Disease
_____Cancer
_____Chemical Dependency
_____Chemotherapy
_____Circulation Problems
_____Cortisone Treatments
_____Cough Persistent
_____Cough up Blood
_____Diabetes
_____Epilepsy
_____Fainting
_____Glaucoma
_____Headaches
_____Heart Murmur
_____Heart Problems
_____Hemophilia/Abnormal Bleeding
_____Herpes
_____Hepatitis
_____High Blood Pressure
_____Jaw Pain
_____Kidney Disease or Malfunction
_____Liver Disease
_____Mitral Valve Prolapse
_____Nervous Problems
_____Pacemaker/Heart Surgery
_____Psychiatric Care
_____Rapid Weight Gain or Loss
_____Radiation Treatment
_____Respiratory Disease
_____Shingles
_____Shortness of Breath
_____Skin Rash
_____Spinal Bifida
_____Stroke
_____Surgical Implant
_____Swelling of Feet/Ankles
_____Thyroid Disease
_____Tobacco Habit
_____Tuberculosis
_____Ulcer/Colitis
_____Venereal Disease

Updates (To be filled in at future appointments)

Has there been any changes in your health since your last dental appointment? Yes/No

For what conditions? _____

Are you taking any new medications? Yes/No _____

Patient's Signature _____ Date _____

To better serve you, please take a minute to answer the following questions

Please check any of the following problems that apply to you:

- Sensitivity (hot, cold or sweet) If so, which teeth? _____
- Headaches, earaches, neck pain _____
- Teeth or fillings breaking
- Grinding or clenching teeth
- Bleeding, swollen, or irritated gums
- Loose, tipped or shifting teeth
- Bad breath

Who was your previous dentist?

Name _____

Last cleaning _____ Last x-rays _____

Do you have or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD) Yes/No

Have you ever had Botox/Botulinum toxin or Dermal fillers? Yes/No

If no, would you be interested in discussing improving your smile with Botox/Botulinum or Dermal Fillers? Yes/No

Do you have sleep apnea? Yes/No If yes, have you had a sleep study in the last 5 years? Yes/No _____

Have you ever worn a CPAP Yes/No

Do you snore? Yes/No

Do you like your smile? Yes/No Explain, _____

Do your gums ever bleed? Yes/No How many times a day do you brush? _____

If you could change your smile, would you:

- Make your teeth whiter
- Make your teeth straighter
- Close spaces between teeth
- Replace silver/mercury fillings
- Repair chipped teeth
- Repair missing teeth
- Replace old crown that don't match
- Have a smile makeover
- Smooth out wrinkles around my lips and mouth
- Have a less 'gummy' smile

What is the most important thing to you about your dental visit today?

_____

When you think of cosmetic dentistry, you may not think about Botox/Botulinum and dermal fillers. But the truth is the appearance of your mouth and smile has a lot to do with how attractive you look and feel. Our doctors have the skill and know-how to use Botox/Botulinum and dermal fillers to enhance your lips, smooth lip lines, and eliminate wrinkles around the mouth to create a more beautiful and youthful appearance. We can offer these services during routine dental appointments in a completely painless manner with more training and knowledge in oral and oral-facial areas than any other health care professional. Let our staff know if you are interested in discussing Botox/Botulinum and dermal fillers with our doctors.

Insurance Information and Patient Understanding

Please note that your treatment plan which shows your insurance estimate is just an **"estimate" and NOT a guarantee of payment**. Some teeth may have hidden decay or affected nerves requiring additional treatment at additional cost. You will be notified of any changes in your treatment plan. There are several procedures that are frequently downgraded and given an alternate "less costly" benefit. When this occurs, the patient is responsible for the difference between the service that we provide and the service that is paid when processed by your insurance company. This will be billed to you after the claim has been paid.

Patient's that have dental insurance must understand that all procedures are billed directly to the patient. We never know **"exactly"** what your insurance will pay and the portion listed as the patient "portion" is an estimate only. Our office will assist in making collections from your insurance company by filing all necessary forms; however, if there is a balance remaining after your insurance company pays your benefit, you will be billed for any amount due that exceeds your benefit coverage.

_____ _____

Patient Signature Date

Signing this estimate implies that the patient has read and understands the policy concerning insurance and billing and does not obligate the patient to schedule an appointment.

ESTIMATE GOOD FOR 90 DAYS

NOTICE OF PRIVACY PRACTICES

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 Waldman 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 Waldman 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: _____