Brentwood Family Dentistry
Patient Information

Name: _____ Sex:_____ Social Security #:_____

Address: _____ City _____ State_____ Zip_____

Birth Date: _____ Cell Phone: _____ Home Phone: _____

Occupation: _____ Employer: _____ Work Phone: _____

Spouse's Name: _____ Employer: _____ Spouse Birth date:_____

Primary Dental Insurance: _____ Policy or Member #:_____

Secondary Dental Insurance: _____ Policy or Member #:_____

Who is responsible for this account? name/relationship/social security: _____

How did you learn of our office? _____

Medical History

Physician: _____ Approximate date of last physical: _____

Are you under any medical treatment now? _____If so, for what? _____

Medications: _____

Allergies: _____

Have you had any major operations? _____ If so, for what and when? _____

	YES	NO		YES	NO
Heart Issues/Heart Surgery	_____	_____	Diabetes Type 1/Type 2	_____	_____
Heart Attack	_____	_____	Respiratory Disease	_____	_____
Heart Valve Defect/Repair	_____	_____	Liver Disease/Hepatitis	_____	_____
High Blood Pressure	_____	_____	Kidney Problems	_____	_____
Stroke	_____	_____	HIV/ AIDS	_____	_____
Abnormal Bleeding	_____	_____	Autoimmune Disease	_____	_____
Hip/Knee/Joint Replacement	_____	_____	Osteoporosis	_____	_____
Epilepsy/Seizure Disorders	_____	_____	Cancer/Radiation/Chemo	_____	_____

	YES	NO
Women: Are you pregnant?	_____	____
Breast-feeding?	_____	____
Taking birth control pills?	_____	____

Dental History

Is there anything you would like to change about your teeth?

_____

When was the last time you saw a dentist for treatment? _____

Have you ever had any unusual reactions to local anesthetic? _____

Do you feel there is anything else your doctor needs to know about your medical or dental condition? _____

_____

Signature: _____ **Date:** _____

Doctor's Signature : _____

(Payment is due at time of service unless previous arrangements have been made. Collection fees will be added to accounts not kept current.)

BRENTWOOD FAMILY DENTISTRY

ACKNOWLEGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDEMENT

I, _____, have received a copy of this office's notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices. Acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (Please specify)

_____

_____

_____

OUT-OF-NETWORK CONSENT FORM

By signing, I understand that I may have to pay more for out-of-network care.

With my signature, I'm agreeing to get the items or services from: Brentwood Family Dentistry

With my signature, I acknowledge that I'm consenting of my own free will and I'm not being coerced or pressured. I also acknowledge that:

• I may have to pay the full charges for these items/services and or additional out-of-network cost-sharing under my health plan.

• I was given a notice on paper that explained my provider or facility isn't in my health plan's Network.

• I fully and completely understand that some or all the amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.

• I can end this agreement by notifying the provider or facility in writing before getting services.

IMPORTANT: You don't have to sign this form. If you don't sign, this provider or facility might not treat you, but you can choose to get care from a provider or facility that's in your health plans network.

_____

_____

Patient or Guardian's signature Printed name & relationship

_____

Date

Take a picture and/or keep a copy of this form.

It contains important information about your rights and protections.