THOMAS F. BROWN, DDS
FAMILY & SEDATION DENTISTRY

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: M or F Family Status: Married Single Child Other

Birth Date: _____ SS#: _____ E-Mail Address _____

Employer: _____ Position: _____ Driver's License #: _____

Phone: _____ (Home) _____ (Mobile) _____ (Work)

Address: _____

_____ (City) ____ (State) _____ (Zip Code)

Who is Responsible for the account? _____

If patient is considered a minor (under 18 years old):

Relationship to patient: Parent/Guardian Person Responsible for Account Relative: _____
Please Indicate Relationship

Emergency Contact Info:

_____ (Name) _____ (Phone #) _____ (Address)

How did you hear about our dental office? Please check one

- ☐ Family/Friend/Coworker
- ☐ NP Online Special
- ☐ Dental Insurance Website
- ☐ Walk by/Location
- ☐ Google/Internet Search
- ☐ Flyer in Mail
- ☐ Doctor Referral
- ☐ Facebook
- ☐ Yelp

Name of friend, family, or Co-Worker that referred you? (We would like to thank him or her!)

_____

Dental Information

On scale 1-10 (1-poor, 10-excellent) what would you rate your current smile? 1 2 3 4 5 6 7 8 9 10

On scale 1-10 (1-poor, 10-excellent) what would you like your smile to be at? 1 2 3 4 5 6 7 8 9 10

What is the reason for your visit today?

_____

_____

_____

Do you have any immediate concerns?

_____

_____

_____

Teeth: Have you experienced any of the following?

- ☐ Sensitivity to hot/cold
- ☐ Sensitivity to sweets
- ☐ Sensitivity to biting/chewing
- ☐ None

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Esthetics

Are you interested in whitening? Y or N

Are you interested in straightening your teeth? Y or N

Have you considered Botox to relax facial lines and wrinkles? Y or N

If there was anything you could change about your smile, what would it be? (spacing, alignment, color, etc)

In all sections, please check all that apply to you

Sleep
- ☐ Loud Snoring
- ☐ Feeling tired, fatigued, or sleepy during daytime
- ☐ Fall asleep easily watching TV, being passenger in car, sitting or reading
- ☐ Has anyone observed you stop breathing while sleeping
- ☐ You have or have been treated for High Blood Pressure
- ☐ You are 50 years of age or older
- ☐ Been diagnosed with obstructive sleep apnea? (OSA)
- ☐ Currently being treated for OSA
- ☐ Aware of a family history of OSA
- ☐ You wear a CPAP at night
- ☐ None of the above

Gums
- ☐ Bad Breath
- ☐ Bleeding or sore gums
- ☐ Food caught in between the teeth
- ☐ Loose teeth or change in bite
- ☐ Parents with gum disease or tooth loss
- ☐ Cold sores, blisters, or oral lesions
- ☐ None of these

Jaw & TMJ
- ☐ You wear a night guard
- ☐ Tired jaw, especially in morning
- ☐ Clenching/grinding while asleep or awake
- ☐ Regularly biting cheeks or lips
- ☐ Clicking or popping of the jaw
- ☐ Pain in jaw joint, ear, or side of face
- ☐ Difficulty in opening or closing mouth
- ☐ Headaches, neck aches, or shoulder aches
- ☐ Sore muscles in neck, shoulders, or face
- ☐ Have you sought treatment for TMJ pain before?
- ☐ Has anyone observed you grinding your teeth while asleep?
- ☐ None of these

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MEDICAL HISTORY

Please check all that apply

Medical Conditions

- ☐ Anemia
- ☐ Angina
- ☐ Artificial Joints
  If yes, please list surgery date:_____
- ☐ Asthma
- ☐ Auto-Immune
- ☐ Blood Disease
- ☐ Blood Thinner
- ☐ Cancer
- ☐ Cong. Heart Failure
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ History of Stroke
- ☐ HIV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Mental Disorder
- ☐ Migraine Headaches
- ☐ Mitral Valve Pro
- ☐ Nervous Disorders
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Rapid Weight Loss
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Seizures
- ☐ Sickle Cell Disease
- ☐ Sinus Problems/ Troubles
- ☐ Thyroid Problem
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other:_____

Pre-Meds

- ☐ Amoxicillin
- ☐ Clindamycin
- ☐ Other:_____

Allergy

- ☐ Aspirin
- ☐ Latex
- ☐ Codeine
- ☐ Erythromycin
- ☐ Penicillin
- ☐ Hay Fever
- ☐ Sulfa
- ☐ Other:_____

Please answer the following

Do you see a physician for yearly physicals? Approximately, when was your last physical exam? _____

Have you been hospitalized, had any major surgeries, illnesses, or diagnoses in the past two years? If YES, please explain

_____

Do you have any history of heart surgeries or heart conditions? If YES, please explain

_____

Please list ANY medications you are currently taking? (*including ANY pre-meds*)

_____

_____

_____

***REQUIRED (patient OR parent of minor)**

***Print Name:**_____

***Signature:**_____

***Date:**_____

*Are there any changes to your medical history since your last dental visit?
If yes, please list: _____

Are you taking any blood thinning medication?

- ☐ No, I am not
- ☐ Warfarin/Coumadin
- ☐ Plavix
- ☐ Other:_____
- ☐ Daily Aspirin
- ☐ Xarelto
- ☐ Pradaxa

Are you taking any or have taken bone loss drugs? Y or N
If yes, please list:_____

Have you taken any prescription weight loss drugs in past? Y or N
If yes, please list:_____

Have you had your heart examined in past? Y or N

Do you use any tobacco products? (Cigarettes, cigars, etc) Y or N

If you are diabetic, what are your most recent blood glucose & HbA1c?

_____

FOR WOMEN:

Are you pregnant, or could you be pregnant? Y or N
Are you currently nursing? Y or N

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Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to counseling to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre & post treatment instruction, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so he/she can consult with your physician if necessary.

The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist. If you are a woman on oral birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with you physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

Further, I understand that I am entering into a contractual relationship with Dr. Thomas Brown for professional care. I further understand that meritless and frivolous claims for dental malpractice have an adverse effect upon the cost and availability of dental care, and may result in irreparable harm to a dental provider. As additional consideration for professional care provided to me by Dr. Thomas Brown, I agree not to advance, directly, or indirectly any false, meritless, and/or frivolous claim(s) of medical/dental malpractice against Dr. Thomas Brown.

Furthermore, should a dental malpractice case or cause of action be initiated or pursued, I agree to use expert witness (es) who practice primarily in the same specialty as Dr. Thomas Brown. Furthermore, I agree that these expert witnesses will be members in good standing of and adhere to the guidelines and/or code of conduct designed for expert witnesses by the American Dental Association. In further consideration for this, Dr. Thomas Brown agrees to same stipulations.

I acknowledge that monetary damages may not provide an adequate remedy for breach of this agreement. Such breach may result in irreparable harm to doctor's reputation and business. Both Dr. Thomas Brown and I agree in the event of a breach to allow specific performance and/or injunctive relief.

As with all healthcare treatment, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly known risks and complications of treatment include but are not limited to the following:

1. Pain, swelling and discomfort after treatment
2. Infection in need of medication, follow-up procedures or other treatment
3. Temporary, or on rare occasion permanent numbness, pain, tingling, or altered sensation of lip, face, chin, gums, and tongue along with possible loss of taste.
4. Damage to adjacent teeth, restorations or gums
5. Possible deterioration of your condition which may result in tooth loss
6. The need for replacement of restorations, implants, or other appliances in the future
7. An altered bite in need of adjustment
8. Possible injury to the jaw joint and related structures requiring follow-up care and treatment or consultation by a dental specialist
9. A root tip, bone fragment or a piece of dental instrument may be left in your body and may have to be removed at a later time if symptoms develop
10. Jaw fracture
11. If upper teeth are treated, there is a chance of sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment.
12. Allergic reaction to anesthetic or medication
13. Need for follow up treatment, including surgery.

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain all your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

Patient Print Name: _____

Patient Signature (parent/guardian please sign for minor): _____

Date: _____

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Financial Policy

Our office takes payment in full for all services on the date of service

If a patient's insurance has not paid within 90 days of treatment, the patient will be responsible for the full payment. In such cases, our office will assist in resubmitting all claims and appeals.

Thank you for your understanding.

Patient Signature (parent/guardian please sign for minor): _____

Date: _____

Missed Appointment and Cancellation Policy

We understand that schedules change. If you are unable to keep a scheduled appointment, we kindly ask you to give our office 48 hour advanced notice to ensure you will not be charged a cancellation fee.

****If less than 48 hour notice is given to cancel an appointment, you will be charged a standard cancellation fee****

Please note: We do not accept voicemails or any other left message, in the event that you need to make changes to your scheduled appointment. (e.g. cancellations or rescheduling). You are required to call during regular business hours to speak with an administrative professional regarding any changes to your appointment. We thank you in advanced for your cooperation.

Patient Signature (parent/guardian please sign for minor): _____

Date: _____

HIPAA Acknowledgement

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involves in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you any time to obtain the most current copy of this notice.

I understand that I have the right to request restriction on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

Please check all that apply:

- ☐ You may contact me at my home telephone number
- ☐ You may contact me on my mobile telephone number
- ☐ You may contact me on my work telephone number
- ☐ You may send me an e-mail
- ☐ Other:_____

Patient Signature (parent/guardian please sign for minor):

_____

Date:_____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:(example: John Doe (212-555-1212)

Name:_____

Phone # _____

Name:_____

Phone # _____

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Photo Use Release Form

I, _____, hereby grant and authorize **Thomas F. Brown, DDS** the right to take, edit, alter, copy, exhibit, publish, distribute, and make use of any and all pictures or video taken of me to be used in and/or for legally promotional materials including, but not limited to, newsletters, flyers, posters, brochures, advertisements, fundraising letters, annual reports, press kits, and submissions to journalists, websites, social networking sites, and other print and digital communications, without payment or any other consideration. This authorization shall continue indefinitely, unless I otherwise revoke said authorization in writing.

I understand and agree that these materials shall become the property of **Thomas F. Brown, DDS** and will not be returned.

I hereby hold harmless, and release **Thomas F. Brown, DDS** from all liability, petitions, and caused of action which I, my heirs, representative, executers, or any other persons may make while acting on my behalf or on my behalf of my estate.

_____

Name (patient OR parent/guardian, if minor)

_____

Signature

_____

Date

☐ I hereby decline permission and consent for photo use

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Minor Release Form

All persons under the age of 18 are required to have a parent or guardian fill out this form.

By signing below, you agree that you are the parents or legal guardian of the minor receiving treatment at our facility. If the minor receiving treatment is under the age of 13, you understand that you are required to remain at the facility for the entirety of the minor's treatment. You will also be required, if needed, to assist the minor in prepping for his or her treatment. We may also request that you may remain in the treatment room to supervise all interactions between the provider and the minor.

PLEASE PRINT CLEARLY <u>IF MINOR UNDER AGE OF 13</u>

I, _____, certify that I am the parent or legal guardian of _____, who is _____, years of age as of today. I have completed the intake form for the above mentioned minor and informed the provider of all relevant medical history and concerns. I understand the scope of dental treatment and I understand that I may not leave the facility during the time where my minor is receiving treatment.

By signing below, you agree that you are the parents or legal guardian of the minor receiving treatment at our facility. If the minor receiving treatment is between the ages of 14 to 17, you understand that you may leave the facility during minor's treatment. You understand that by signing on the line below you are giving authority and permission for the provider to undergo treatment on the minor without the parent or legal guardian present at the facility.

PLEASE PRINT CLEARLY <u>IF MINOR BETWEEN AGE OF 14 TO 17</u>

I, _____, certify that I am the parent or legal guardian of _____, who is _____, years of age as of today. I have completed the intake form for the above mentioned minor and informed the provider of all relevant medical history and concerns. I understand the scope of dental treatment and I give my permission for above mentioned minor to receive treatment without my active presence at the facility.

Print Name

_____

Signature

_____

Date

_____

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Dental Insurance or Dental **Assistance**?

Dental Benefits are **NOT** really *Insurance* in the classic sense.

*If you have needs other than healthy cleanings, your care **will** require an investment beyond what your "insurance" will cover. Your benefits will assist you in the maintenance of your dental health but were never designed to be all you need.*

It's not news that employers have reacted to the rising costs of health care benefits by shopping carefully for the policies that they offer their employees. Benefits are down, restrictions and exclusions are up. Our patients share their resulting frustration with us every day. Adding to the frustration is the fact that dental benefits are often represented as being comparable to other types of insurance. "Insurance", by definition, is protection against unpredictable or catastrophic loss. But most dental benefit plans specifically *exclude* extraordinary needs. The things offered as benefits are not only predictable, but expected, such as routine exams, x-rays, healthy cleanings, etc. Further, policies that do offer a benefit for other common services, such as crowns and treatment for gum disease, provide them at a much lower percentage of the actual cost of providing that care, and with a low dollar limit per year.

Your dental benefit plan is excellent maintenance assistance program that will help you protect your investment in your dental health, and we're happy you have that assistance!

Another common misrepresentation is that dental "insurance" covers all of the things that you need. We believe this can be a danger to your health, because it implies that *if it isn't covered, you don't need it.* Insurance companies are in business to make money. This is no secret and it's not bad or wrong. Their responsibility to their shareholders is to provide the benefits they can while still creating profit within the investment your employer has chosen to make in dental health. You cannot count on a dental benefit plan to determine what you need; that's your responsibility. It's our responsibility to advise you regarding your health. The fact is, unless you have excellent dental health, your needs will require that you make an investment.

We invest in what we value. Home improvement, education, vacations, is all examples of things we pay for, by choice, because we value them. We don't presume to know where dental health fits in your value system. That's for you to decide. It's important for us that you know we think you're worth the investment, and we'll work with your benefit plan to see that you receive the maximum benefits in assisting you with the maintenance of your health.

We work with and welcome <u>ANY</u> questions about your dental benefit plan

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