

## New Patient Registration

Date: \_\_\_/\_\_\_/\_\_\_

### Patient Information

**PATIENT FIRST NAME:** \_\_\_\_\_ **LAST:** \_\_\_\_\_ **INITIAL:** \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex: Male:  Female:

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell:(\_\_\_\_)\_\_\_\_-\_\_\_\_ Work:(\_\_\_\_)\_\_\_\_-\_\_\_\_ Home:(\_\_\_\_)\_\_\_\_-\_\_\_\_

Marital Status: Single:  Married:  Divorced:  Widowed:  Separated:

Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

Employment Status: Full Time:  Part Time:  Retired:  Student:

**IN CASE OF AN EMERGENCY CONTACT:**

Emergency Contact: \_\_\_\_\_ Phone:(\_\_\_\_)\_\_\_\_-\_\_\_\_

### Dental Insurance

Dental Insurance : Yes:  No:  Insurance Company \_\_\_\_\_

Relation to Subscriber: Self: Spouse: Dependent:

If not self, Subscriber name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Employer: \_\_\_\_\_ Subscriber SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Secondary Insurance: Yes: No: Insurance Company \_\_\_\_\_

Relation to Subscriber: Self: Spouse: Dependent:

If not self, Subscriber name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Employer: \_\_\_\_\_ Subscriber SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Assignment and Release:**

**I authorize release of any information relating to all dental claims and understand that I am responsible for all costs of dental treatment regardless of my insurance coverage.**

Signed \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

### Dental History

Reason for today's visit: Cleaning: Exam: Tooth Pain: Other: \_\_\_\_\_

How often do you brush?: 1x/day: 2x/day: 3+/day: Never:

How often do you floss?: 1x/day: 1x/week: 1x/month: Never:

Date of last dental visit \_\_\_\_\_

Questions or Concerns for the doctor: None: \_\_\_\_\_

Mark  if you have had any of the following:

- |   |  |  |
|---|--|--|
| Bad Breath <input type="checkbox"/>                   | Food collection between teeth <input type="checkbox"/> | Orthodontic treatment <input type="checkbox"/>   |
| Bleeding gums <input type="checkbox"/>                | Grinding teeth <input type="checkbox"/>                | Pain around ear <input type="checkbox"/>         |
| Blisters on lips <input type="checkbox"/>             | Gums swollen/tender <input type="checkbox"/>           | Periodontal treatment <input type="checkbox"/>   |
| Burning sensation on tongue <input type="checkbox"/>  | Jaw pain/tiredness <input type="checkbox"/>            | Sensitivity to cold <input type="checkbox"/>     |
| Chew on one side <input type="checkbox"/>             | Lip or cheek biting <input type="checkbox"/>           | Sensitivity to heat <input type="checkbox"/>     |
| Cigarette/Pipe/Cigar smoking <input type="checkbox"/> | Loose teeth/broken filling <input type="checkbox"/>    | Sensitivity to sweets <input type="checkbox"/>   |
| Clicking/Popping jaw <input type="checkbox"/>         | Mouth breathing <input type="checkbox"/>               | Sensitivity when biting <input type="checkbox"/> |
| Dry mouth <input type="checkbox"/>                    | Mouth pain <input type="checkbox"/>                    | Sores/growths in mouth <input type="checkbox"/>  |
| Fingernail biting <input type="checkbox"/>            |  |  |



## Medical History

Mark Yes  or No  if you have had any of the following:

AIDS/HIV	Yes <input type="checkbox"/> No <input type="checkbox"/>	Epilepsy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Radiation Treatment	Yes <input type="checkbox"/> No <input type="checkbox"/>
Anemia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Fainting/Dizziness	Yes <input type="checkbox"/> No <input type="checkbox"/>	Respiratory Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Glaucoma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rheumatic Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>
Artificial Heart Valve	Yes <input type="checkbox"/> No <input type="checkbox"/>	Headaches	Yes <input type="checkbox"/> No <input type="checkbox"/>	Scarlet Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>
Artificial Joint	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Murmur	Yes <input type="checkbox"/> No <input type="checkbox"/>	Shortness of Breath	Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sinus Trouble	Yes <input type="checkbox"/> No <input type="checkbox"/>
Back Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis Type _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	Skin Rash	Yes <input type="checkbox"/> No <input type="checkbox"/>
Bleeding abnormally	Yes <input type="checkbox"/> No <input type="checkbox"/>	Herpes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Special Diet	Yes <input type="checkbox"/> No <input type="checkbox"/>
Blood Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Stroke	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>	Jaundice	Yes <input type="checkbox"/> No <input type="checkbox"/>	Swollen Feet/Ankles	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chemical Dependency	Yes <input type="checkbox"/> No <input type="checkbox"/>	Jaw Pain	Yes <input type="checkbox"/> No <input type="checkbox"/>	Swollen Neck Glands	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chemotherapy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Thyroid Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
Circulatory Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Liver Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tonsilitis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Congenital Heart Lesions	Yes <input type="checkbox"/> No <input type="checkbox"/>	Low Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tuberculosis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cortisone Treatments	Yes <input type="checkbox"/> No <input type="checkbox"/>	Mitral Valve Prolapse	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tumor on neck/head	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cough	Yes <input type="checkbox"/> No <input type="checkbox"/>	Nervousness	Yes <input type="checkbox"/> No <input type="checkbox"/>	Ulcer	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pacemaker	Yes <input type="checkbox"/> No <input type="checkbox"/>	Venereal Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Emphysema	Yes <input type="checkbox"/> No <input type="checkbox"/>	Psychiatric Care	Yes <input type="checkbox"/> No <input type="checkbox"/>	Weight Loss	Yes <input type="checkbox"/> No <input type="checkbox"/>

**Women:**

Pregnant: Yes:  No:  Due Date: \_\_\_/\_\_\_/\_\_\_ Nursing: Yes:  No:  Taking oral contraceptives: Yes:  No:

## Medications

Are you taking any medication? Yes:  No:

**List of Medications:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you ever used a bisphosphonate:(Fosamax, Actonel, Atelvia, Didronel, Boniva, Prolia):Yes:  No:

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionian, Adipex, Fastin, Pondimin and Redux :Yes:  No:

Preferred Pharmacy \_\_\_\_\_ Location \_\_\_\_\_

### Allergies

Mark  on any known allergies:

Latex <input type="checkbox"/>	Barbiturates <input type="checkbox"/>
Penicillin <input type="checkbox"/>	Aspirin <input type="checkbox"/>
Sulfa <input type="checkbox"/>	Codeine <input type="checkbox"/>
Local Anesthetic <input type="checkbox"/>	Other <input type="checkbox"/>
Iodine <input type="checkbox"/>	_____

### Other

How did you hear about our office?

Referral <input type="checkbox"/>	Referrer _____
Mailer <input type="checkbox"/>	
TV <input type="checkbox"/>	
Radio <input type="checkbox"/>	
Insurance <input type="checkbox"/>	
Other <input type="checkbox"/>	_____

# BRUSH DENTAL

## FINANCIAL AGREEMENT FOR THE OFFICE OF BRUSH DENTAL

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is an agreement between you, your employer, and the insurance company. Our practice is not a party to that agreement. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full. I agree to pay 18% interest on any balance unpaid, or becomes delinquent, in addition to court costs, and reasonable attorney's fees.

As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our practice by signing the authorization on the Assignment of Benefits Agreement. In order for our practice to file your insurance claim, you must bring in a completed dental insurance form or proof of insurance at each appointment.

Your **estimated** copayment for treatment, which is the amount not covered by your insurance, is due at the time treatment is provided. Your **estimated** copayment may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments. Our practice accepts cash, personal checks, MasterCard, Visa, and Discover. Extended payment financing is available upon request and approval.

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care.

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Print Name of Patient or Responsible Party

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Signature of Patient or Responsible Party

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Date

# BRUSH DENTAL

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activity, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including revisions of our Notice, at any time by contacting Brush Dental.

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to Brush Dental. Please understand that the revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**REVOCACTION OF CONSENT**

I revoke my Consent for use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. Include completed Consent in patients chart.

### PLEASE CHECK ALL THAT APPLY

You may disclose information to my family members and or non-family members. Please list name, phone number, and relationship.

NAME	PHONE NUMBER	RELATIONSHIP

You may leave Protected Health Information on my answering machine/ voicemail.

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Name of Patient: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_