WELCOME TO BROWN DENTAL, P.A.

PATIENT INFORMATION

Patient's Name: _____Today's Date: _____
First Middle Last

Address: _____
Street Apt# City/State/Zip Code

Hm Phone #: _____Cell Phone #: _____Wk Phone #:_____

Date of Birth: _____Social Security #: _____Driver's License#: _____

E-mail: _____

Patient Employed By: _____ Occupation: _____
(Parent's employer and occupation if patient is a minor)

College name and location if patient is a full time student: _____

How did you hear about Brown Dental? _____

Who should we notify in case of an emergency? Name:_____ Phone: _____

Are you available for an appointment on short notice? Yes No Phone:_____

Who is financially responsible for this patient? _____
Full name of person responsible for account

INSURANCE

Primary Dental Carrier:	Secondary Dental Carrier or Medical Insurance:
Insurance Company:_____	Insurance Carrier:_____
Telephone:_____	Telephone:_____
Employer Name:_____	Employer Name:_____
Group Number:_____	Group Number:_____
Insured's Name:_____	Insured's Name:_____
Date of birth:_____	Date of birth:_____
ID No. or SSN:_____	ID No. or SSN:_____
Relationship to patient:_____	Relationship to patient:_____

AUTHORIZATION

**** Even if you don't currently have dental insurance, please review the following policy because you may in the future. Thank you.***

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: _____ Date: _____

PATIENT'S NAME:_____

MEDICAL HISTORY

All information is completely confidential

1. Primary Physician's Name:_____ Phone:_____
   Address:_____
   Street Suite# City/State/Zip
2. Have you ever had any serious illness or operations? Yes No
   If yes, please describe:_____
3. Have you ever had a blood transfusion? Yes No If yes, when?_____
4. WOMEN: Are you pregnant? Yes No Nursing? Yes No Taking Birth Control Pills? Yes No
5. Do you have or have you ever had any of the following? (Please Circle)

A.I.D.S	Fainting	Pacemaker
Anemia	Headache	Psychiatric Care
Arthritis, Rheumatism	Heart Murmur	Radiation Treatment
Artificial Joints	Heart Problems	Respiratory Disease
Artificial Heart Valve	Describe_____	Rheumatic Fever
Asthma	Hemophilia	Scarlet Fever
Sickle Cell Disease	Hepatitis	Shortness of Breath
Blood Disease	High Blood Pressure	Skin Rash
Cancer/Tumor	HIV Positive	Stroke
Chemical Dependency	Jaw Pain	Swollen Feet/Ankle
Circulation Problems	Kidney Disease	Thyroid Problems
Cortisone Treatments	Liver Disease	Tobacco Habit
Diabetes	Latex Sensitivity	Tonsillitis
Epilepsy	Metal Allergies (e.g:Nickel)	Tuberculosis
Ulcer	Mitral Valve Prolapse	or +PPD Skin Test
Eye Problems	Prolonged Bleeding	Venereal Disease

6. Do you have any disease or condition not listed above? Yes No
   If yes, please describe:_____
7. Please list any medications you are currently taking or have taken within the last six months:
   _____
   _____
   _____
8. Do you have any allergies to any drug or medication? Yes No If yes, please list:
   _____
   _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, the doctor has my permission to ask the respective health care provider or agency who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature:_____ Date:_____

GENERAL CONSENT

I hereby authorize Dr. Tim P. Brown/Dr. Anh D. Brown or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis.

If diagnostic models/casts are made, they will be kept for 6 months, after which they will be disposed. If you would like to have your diagnostic casts please let us know.

Upon such diagnosis, I authorize Dr. Tim P. Brown/Dr. Anh D. Brown to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. There is no guarantee as to the long term success of treatment-even under ideal conditions or circumstances. Any treatment can fail due to other factors beyond the doctors control. I understand that a perfect result is not and cannot be guaranteed or warranted.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Patient/Guardian Signature:_____ Date:_____

OFFICE POLICY

Please review the following courtesies. Thank you for your cooperation.

- If you are unable to make a scheduled appointment, please provide our office with at least 24 hours notice. **In the event that an appointment is missed and 24-hour notice was not given, our office may charge a fee of $25 M-F.** Time lost due to missed appointments cannot be recovered.

- Emergencies will be seen. Please be aware that emergency patients are "fit-in" between regularly appointed patients. Our scheduled patients will always have first courtesy. Emergency patients will be seen as soon as possible, but there may be a waiting period.

- For **first** time emergency patients to our office, we ask that payments be made by either cash or credit card. For subsequent visits and when credit has been established with our office, we accept cash and credit cards. **NO CHECKS.**

- **To protect the privacy of our patients, only the patient receiving treatment will be allowed in the treatment room.**

- By Texas law, all original records, x-rays and models belong to the dentist. If you desire duplicate copies, please allow our office at least 72 hours. There is a fee depending on the amount of material to be duplicated.

- **Refund/Return Policy: When dental services have been initiated they cannot be refunded.**

I have read, understand and agree to abide by the office policies outlined herein.

Signature:_____ Date:_____

Patient/Parent or Guardian

**** Even if you don't currently have dental insurance, please review the following policy because you may in the future. Thank you.***

OFFICE POLICY
Traditional Insurance

- As a courtesy to our patients, our office will accept your insurance benefits on assignment ***provided that benefits have been verified prior to the visit.*** The patient is responsible for all charges incurred including those for services not covered or denied by the patient's insurance company.

- Please provide our office with all necessary information concerning your insurance as well as all pertinent information about you and/or the insured.

- We will charge co-payments based upon our office fees and your breakdown of insurance coverage. Please be aware that any benefits quoted by your insurance company may not be actual. When all payments have been received and accounted for, we will refund to you any overpayment and, likewise, will bill you for any balance outstanding.

- We are not responsible for denied or reduced insurance payments. Any discrepancy of amounts paid or not paid by your insurance company must be resolved between you and the insurance company. You are responsible for the total charge of services rendered.

- **All co-payments are due at the time services are rendered**.

I have read, understand, and agree to abide by the policies outlined herein.

Signature:_____ Date:_____
Patient/Parent or Guardian

AKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been given the opportunity to review a copy of BROWN DENTAL, P.A.'s Notice of Privacy Practices.

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I authorize **BROWN DENTAL, P.A.** to use and disclose the specific health and medical information described below:

The specific health and medical information include: (this is not an all inclusive list)

- Name, Address, Phone number, FAX number
- Social Security Number, Plan Beneficiary Number
- Date of Birth, License Number
- Employer
- Account Information
- X-Rays (original or duplicate)
- Treatment Plan
- Medical History

Recipients: Family , Legal Guardian
And Class of Recipients: Insurance Companies, Pharmacies, Dental Labs, Medical Doctors, Dentists
For the purpose of:

- Sending recall cards, i.e., reminders for check-up
- Sending statements
- Verification of insurance (eligibility, breakdown of benefits, history of usage especially for procedures with frequency limitations)
- Filing of insurance claims for payments and procedures done
- Submitting predetermination requests to insurance company for future treatment
- Phoning in prescription to pharmacy
- Referral to other dental provider (general or specialist)
- Consultation with primary medical doctor in order to coordinate/modify treatment
- Appointment reminder/confirmation (via telephone/voicemail message)
- Sending cases to dental laboratories

Please inform us if you have any restrictions on the above disclosure.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

I have reviewed and understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

Signature:_____ Date:_____
Patient or Patient's Representative