DENTISTRY by Brooksher

Patient Information

Name_____ Today's Date _____
SS#_____-____-_____ Date of Birth ___ /___ /___
Address_____ Apt. #_____
City_____ State___ Zip _____
Home Phone (____)_____ Work Phone (____)_____ Ext____
Cellular (___)_____ Driver's License Number_____
E-Mail Address _____
Please Circle: Male/Female Single/Married/Divorced/Widowed Full Time Student
Employer_____ Occupation_____
Emergency Contact _____ Relationship_____
Emergency Contact's Telephone # (___)_____

Whom may we thank for referring you? _____

Responsible Party Information

Name _____ Relationship _____
Address_____ City_____ State___ Zip _____
SS#_____-____-_____ Date of Birth ___ /___ /___
Home Phone (____)_____ Work Phone (____)_____ Ext____
Cellular (___)_____

Dental Insurance Information

Subscriber's Name _____
Subscriber's Address _____
SS#_____ DOB _____/_____/_____
Employer Name _____
Insurance Company Name _____ Group#_____
Insurance Company Address _____
City _____ State ____Zip_____ Phone _____

Dental History (*please check yes or no*)

Yes	No	
☐	☐	Have you ever had orthodontic treatment (braces)?
☐	☐	Have you ever bleached your teeth?
☐	☐	Have any of your teeth been removed? ☐ Wisdom teeth ☐ Other Teeth
☐	☐	Have you had dental surgery (other than wisdom teeth)?
☐	☐	Have you ever been told that you have gum disease?
☐	☐	If yes, have you had Periodontal Treatment?
☐	☐	Do you wear a removable prosthesis (complete or partial denture) to replace missing teeth?
☐	☐	Do you wear or have you worn a splint/bite appliance?
☐	☐	Have you ever experienced discomfort or noise in either of your jaw joints?
☐	☐	Have you ever been aware of or has it been suggested that you grind your teeth?

Medical History

Primary care physician _____

Have you been under the care of a doctor within the past 2 years? Yes/No

Have you been a patient in the hospital or emergency room within the last 2 years? Yes/No

Allergies to Medication and/or Other allergies_____

_____

List all medications you are taking _____

_____

_____

What other drugs or medications have you taken within the past 2 years? _____

_____

Ladies: if pregnant? Yes/No Due Date_____ Nursing Yes/No Oral Contraceptive Yes/No

(please circle if you have or have had any of the following)

Prosthetic Heart Valve	Stroke	Asthma	Migraines
Congenital Heart Defect	Tumor	Colitis/Crohn's Disease	Glaucoma
Angina	Cancer	Anxiety Disorder	Hemophilia
Heart Murmur	Radiation Therapy	Clinical Depression	Excessive Bleeding
Dysrhythmia	Chemotherapy	ADHD	Sickle Cell Anemia
Heart Attack	Diabetes I/II	ADD	STD
Heart Failure	Thyroid Disease	Alcohol/Drug Abuse	HIV+ / AIDS
Infective Endocarditis	Kidney Disease	Osteoporosis	Herpes/ Cold Sores
Pacemaker	Liver Disease	Prosthetic Joint	Seizures
Heart Surgery	Hepatitis	Arthritis	Epilepsy
High Blood Pressure	Tuberculosis	Headaches	Do you smoke or use smokeless tobacco?

Please elaborate on any of the above circled **OR** any other conditions not listed:

_____

_____

I certify that I have read and understand the above information. I acknowledge that I have answered the above questions correctly and to the best of my ability and that any questions that I may have had have been answered to my satisfaction. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

(Patient/Guardian Signature) (Date)

DENTISTRY by Brooksher

Self-Assessment Form

The design of this worksheet is to help you begin to explore the priorities you would like us to consider during your first meeting with us. This form will become part of your permanent records.

What is most important for you to accomplish during your first visit?

What concerns do you have about your dental health?

What do you desire for your dental health and the appearance of your teeth?

What dental experiences do you hope not to have repeated?

Accredited Member
AMERICAN ACADEMY OF COSMETIC DENTISTRY

"Have you felt the attraction of a beautiful smile?"

DENTISTRY by Brooksher

Important Practice Information

APPOINTMENTS AND CANCELATIONS

Your time is extremely important to us! Our goal is to honor the time we have reserved just for you. In turn we ask that you honor our time by arriving on time and giving as much notice as possible when making changes to your appointments.

Our schedule is designed to operate at maximum efficiency, appointments are not overbooked. Late changes or failed appointments leave us with nothing to do, which can become very costly.

- It is the responsibility of the patient/guardian to know when they are scheduled
- We require 2 business days to cancel or make changes to your appointment
- A $55.00 fee may be charged after the 3rd late cancellations and/or failed appointment
- It is the responsibility of the patient or guardian to inform us of any changes in contact information

DENTAL INSURANCE AND PATIENT RESPONSIBILITIES

Though we contact your insurance company for eligibility and plan benefits it is the responsibility of the patient or guardian to know whether they are eligible for benefits, as well as the frequency limitations and covered benefits of their plan.

Payment and benefit estimations are *not* a guarantee of payment by your insurance provider, it is our best estimation of benefits based on the information provided by your insurance company.

The patient or guardian is responsible for all:

- Denied procedures or services
- Remaining account balances

FINANCIAL

Payment is expected at time of service.

Payment types include all major bank cards, Master Card, Visa, American Express, Discover, Cash, Money Orders, and Care Credit; we are not set-up to accept checks.

I have been notified by the office of Dr. Steven H. Brooksher that reimbursement for certain services and/or procedures may be denied by my dental insurance coverage and I agree to be personally and fully responsible for payment of same.

_____ _____

(Patient or Guardian Signature) (Date)