Brookfield Family Dentistry, LLC

Marianne Morelli, D.M.D.

PATIENT INFORMATION

Patient Name: _____ Date: _____
Last First Middle Nickname

Gender: *Female* *Male* Family Status: *Single* *Married* *Divorced* *Widowed* *Child*

Date of Birth: _____ Social Security Number: _____

Phone Home: _(_____)_____ Cell : _(_____)_____ Work_(_____)_____

Preferred Contact Number: ☐Home ☐ Cell ☐ Work

Email: _____

Address: _____
Number Street Unit/Apartment Number

_____
Town State Zip Code

INSURED OR RESPONSIBLE PARTY

The information below is for: ☐ the primary subscriber ☐the person responsible for payment ☐ same as above

Name: _____ Date: _____
Last First Middle Nickname

Gender: *Female* *Male* Family Status: *Single* *Married* *Divorced* *Widowed* *Child*

Date of Birth: _____ Social Security Number: _____

Phone Home: _(_____)_____ Cell : _(_____)_____ Work_(_____)_____

Email: _____

Address: _____
Number Street Unit/Apartment Number

_____
Town State Zip Code

DENTAL INSURANCE INFORMATION

Do you have dental insurance? ☐ Yes ☐ No

Primary Dental Insurance Company: _____

Policy Identification Number:_____ Group Number: _____

Policy Holder: _____ DOB: _____ Relation to Patient:_____

Insured's Employer Name: _____ Occupation _____

Secondary Dental Insurance Company: _____

Policy Identification Number:_____ Group Number: _____

Policy Holder: _____ DOB: _____ Relation to Patient:_____

Insured's Employer Name: _____ Occupation _____

REFERRAL INFORMATION

How did you hear about us? _____
Patient/Office Name, Internet, Newspaper, Insurance Company, Advertisement

May we send a thank you note to the party that referred you to our office? _____

OVER

DENTAL HEALTH HISTORY

Patient Name _____

DENTAL HISTORY

Reason for Today's Visit_____ Date of Last Dental Cleaning/X-rays_____

Please check if you have had problems with any of the following:

☐ Bad Breath	☐ Grinding teeth	☐ Sensitivity to hot
☐ Bleeding gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food collection between teeth	☐ Sensitivity to cold	☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Do you need to premedicate with antibiotics for dental appointments? ☐ No ☐ Yes ☐ Unsure

Physician's Name_____ Date of Last Visit _____

Have you been admitted to a hospital, needed emergency care or had any surgeries during the past 5 years?

☐ No ☐ Yes If yes, please explain _____

Do you have a history of chemical dependency? ☐ No ☐ Yes If yes, please explain _____

Have you taken medications (Fosamax, Actonel, Boniva, Reclast) to increase bone density and/or to prevent bone loss?

☐ No ☐ Yes If yes, How long? What type? Are you still taking? _____

(Women) Are you Pregnant? ☐ No ☐ Yes Nursing? ☐ No ☐ Yes Taking Birth Control Pills? ☐ No ☐ Yes

Please check if you have or have had any of the following:

☐ Anemia	☐ Diabetes	☐ HIV / AIDS	☐ Sinus Problems
☐ Arthritis, Rheumatism	☐ Dizziness	☐ Kidney Disease	☐ Sleep Apnea / CPAP
☐ Artificial Heart Valves*	☐ Epilepsy	☐ Liver Disease	☐ Stroke
☐ Artificial Joints*	☐ Excessive Bleeding	☐ Low/High Blood Pressure	☐ Thyroid Problems
☐ Asthma	☐ Fainting	☐ Mental Disorders	☐ T.M.J.
☐ Back Problems	☐ Glaucoma	☐ Mitral Valve Prolapse*	☐ Tobacco Habit
☐ Blood Disease	☐ Hay Fever	☐ Nervous Disorders	☐ Tuberculosis
☐ Cancer	☐ Head Injuries	☐ Osteoporosis**	☐ Tumors
☐ Chemical Dependency	☐ Heart Disease	☐ Pacemaker	☐ _____
☐ Chemo/Radiation	☐ Heart Murmur*	☐ Respiratory Problems	☐ _____
☐ Circulatory Problems	☐ Hepatitis	☐ Rheumatic Fever	☐ _____

MEDICATIONS

List medications you are currently taking:_____

_____

_____

_____

Pharmacy Name/Location:_____

ALLERGIES

☐ Aspirin	☐ Sulfa
☐ Barbiturates (Sleeping pills)	☐ Latex
☐ Codeine	☐ _____
☐ Local Anesthetic	☐ _____
☐ Penicillin	☐ _____

SIGNATURE

To the best of my knowledge, all of the preceding answers and information provided is accurate and complete. If I ever have any change in my health, I will inform the doctor and/or hygienist at the next appointment without fail.

Date _____ Signature_____

Brookfield Family Dentistry, LLC

Marianne Morelli, D.M.D.

Patient Name: _____ Date: _____

Consent for Services

Patients without dental insurance are expected to pay in full at the time services are rendered unless prior arrangements have been made.

Patients with dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. As a courtesy to our patients the office will help prepare insurance forms, submit claims to in network insurance companies, and assist in the adjudication of claims. To help determine your estimated "co-payment" for necessary treatment we may request a pre-determination of benefits. Any estimate "co-payment" that is received as a result of a pre-determination or given verbally by office assignee is not a guarantee of insurance payment; it is subject to plan maximums, usage and limitations. Emergency services do not allow us time to request a pre-determination of benefits and must be paid for at the time services are rendered. Please remember, insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is the responsible party/patient's responsibility to pay any deductible, co-insurance or any other balance not paid for by your insurance company. It is the patient or subscriber's responsibility to know the insurance benefits including, but not limited to: yearly maximum, amount used to date, and treatments covered/not covered.

Patients with or without dental insurance as a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and the financial responsibility on the part of each patient must be determined before treatment. In the event payments are not received by the agreed upon date, I understand that a 1.5% finance charge per month (18% APR) may be added to my account. If it becomes necessary to collect any sum of money through a collection agency and/or an attorney, the patient (and/or spouse/guarantor) agrees to pay all costs of collection, including court and attorney's fees.

In consideration for the professional services rendered to me by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or her assignee, at the time said services are rendered, or within thirty days of billing if credit shall be extended. If I do not cancel an appointment with at least 24 hours notice, I will be charged a fee of $75.00 per scheduled hour.

I grant my permission to the doctor or office assignee, to telephone me at home, cell or at my work to personally discuss matters related to this form and/or my care.

If insured, my signature on this form also serves as a *Signature on File* for my dental insurance. I understand that by signing below I authorize Brookfield Family Dentistry, LLC to release information to my insurance(s) and act as my agent to obtain payment from my insurance company(s). I authorize payment from my insurance(s) directly to Brookfield Family Dentistry, LLC although I understand that I am fully responsible for my bill.

I hereby authorize the dentist and clinical staff members to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care as diagnosed by the dentist.

I have read the above conditions of treatment and payment and agree to their content.

_____

Print name of parent or legal guardian (if under 18)

_____Date: _____ Relationship to Patient:_____

Signature of patient, parent or legal guardian

Over

Patient Name: _____ Date: _____

Privacy Disclosures

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have a right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how your protected health information is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, reliance, signed by you. However, such a revocation shall not affect any disclosures we have already made in your reliance on your prior consent. The practice provides this form to comply with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA.)

The patient/guardian understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practice.
- The patient reserves the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this consent.

_____ I **do not** authorize Brookfield Family Dentistry, LLC to release information concerning my dental care to any individual

_____ I **authorize** Brookfield Family Dentistry, LLC to release information concerning my dental care to the following individuals (family/friends)

Name _____ Relation to Patient_____
☐ Appointment Confirmations ☐ Scheduling of Appointments ☐ Payments on Account

Name _____ Relation to Patient_____
☐ Appointment Confirmations ☐ Scheduling of Appointments ☐ Payments on Account

This consent was signed by: _____ Relation to Patient: _____
Print name of patient, parent or legal guardian

_____ _____
Date Signature of patient, parent or legal guardian