

# 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:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Bad Breath              | <input type="checkbox"/> Grinding teeth                 | <input type="checkbox"/> Sensitivity to hot      | <input type="checkbox"/> Food collection between teeth  |
| <input type="checkbox"/> Bleeding gums           | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets   | <input type="checkbox"/> Sores or growths in your mouth |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment          | <input type="checkbox"/> Sensitivity when biting | <input type="checkbox"/> Sensitivity to cold            |

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

Current Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_

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:

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

## 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 & that he or she is personally responsible for payment of all dental services. As a courtesy to our in-network patients the office will help prepare insurance forms, submit claims to your insurance company(s), & assist in the adjudication of claims. As a courtesy to our out-of-network patients, the office will help submit any claim or pre-authorization to a patient's dental insurance carrier with reimbursement going directly to the patient or insured & assist if you receive a notice that additional information is required. 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 & limitations. Emergency services do not allow us time to request a pre-determination of benefits & 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 & is not a substitute for payment. Some companies pay fixed allowances for certain procedures & 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, & treatments covered/not covered.

**Patients with or without dental insurance** as a condition of treatment in this practice, 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. 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.

**All patients:** 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. As a condition of treatment in this practice, I understand that an examination by the doctor (subject to an additional charge) must accompany every hygiene appointment. I understand that office utilizes visual surveillance in public areas for the protection and safety of all patients and employee's. 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)

\_\_\_\_\_  
Signature of patient, parent or legal guardian

Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

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