Brush Dental

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Queen Creek , AZ 85142

contact@brushdentalaz.com

NEW PATIENT WELCOME PACKET

Welcome and thank you for choosing the Brush Dental team. We strive to provide our patients with the best possible dental care. To help us meet all your dental care needs, please fill out this form completely. If you have any questions or need assistance, please ask us. We will be happy to help.

PATIENT INFORMATION

Please Print Date:_____

Name:_____Preferred Name:_____

Gender: [ ] Male [ ] Female Status: [ ] Minor [ ] Single [ ] Married [ ]Divorced [ ]Widowed

Address:_____

City: _____State:_____ Zip:_____

Home Phone:_____Cell Phone:_____

Birth Date:_____ Social Security #:_____

Email address:_____

Employer:_____Occupation:_____

Who referred you to our office? _____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name:_____Relationship:_____

Birth Date:_____Social Security #:_____

Address:_____

City: _____State:_____ Zip:_____

Employer:_____Occupation:_____

Home Phone:_____Cell Phone:_____

In Case of Emergency:

Contact Name:_____Relationship:_____

Primary Phone:_____Secondary Phone:_____

Please allow the courtesy of 48 hours notice to cancel any scheduled appointment.

MEDICAL HISTORY

Although dentistry treats primarily the area in and around your mouth, other health problems or medications that you may be taking could be relevant to your dental care. Thank you for answering the following questions.

Are you currently under a physician's care? [ ] Yes [ ] No Dr. Name_____Ph:_____

Have you ever been hospitalized or had a major operation? [ ] Yes [ ] No Please explain_____

Please list any medications, vitamins, pills or drugs that you are currently taking _____

_____

Are you on a special diet? [ ] Yes [ ] No Please explain_____

Do you use tobacco? [ ] Yes [ ] No

If so, how interested are you in quitting? VERY / SOMEWHAT / NOT INTERESTED

Do you use controlled substances? [ ] Yes [ ] No Please explain_____

Women

Are you pregnant or trying to get pregnant? [ ] Yes [ ] No Nursing? [ ] Yes [ ] No

Taking oral contraceptives? [ ] Yes [ ] No

Are you allergic to any of the following:

[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Acrylic [ ] Metal [ ]Latex [ ] Local Anesthetics [ ] Percoset

[ ] Amoxicillin [ ] Sulfa [ ] Erythromycin [ ]Morphine [ ] Others_____

Have you ever had any of the following problems or diseases? Please Circle Y / N

Heart disease/attack Y / N	Kidney disease/trouble Y / N	Epilepsy/seizures Y / N	Asthma/RespiratoryY/N
Heart surgery/disease Y / N	Dizziness/Fainting Y / N	Attention Deficit Y / N	Allergies (Seasonal) Y/N
Heart Murmur Y / N	Liver disease Y / N	Psychiatric treatment Y / N	Stroke Y/N
Rheumatic Fever Y / N	Hepatitis A/B/C Y / N	Cancer Y / N	Glaucoma Y/N
Mitral Valve Prolapse Y / N	Blood transfusion Y / N	Chemotherapy/radiation Y / N	Head Injuries Y/N
Artificial Heart Valve Y / N	Hemophilia Y / N	STD/Venereal Disease Y / N	Organ Transplant Y/N
Heart Pacemaker Y / N	AIDS/HIV Y / N	Diabetes Y / N	Artificial Joints Y/N
High Blood Pressure Y / N	SubstanceAbuse/addiction Y/ N	Thyroid Disease Y / N	Oral Cancer Y / N
Anemia Y / N	Cold sores/fever blisters Y / N	Arthritis Y / N	Osteoporosis Y / N
Stomach Problems Y/N	Sinus Problems Y/N	Lyme Disease Y/N	

Have you had a total joint replacement? Y / N Do you require antibiotics before dental treatment? Y / N

Have you ever had a serious illness not listed above? [ ] Yes [ ] No If YES, please explain

_____

_____

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information may be dangerous to my (or the patient's) health. I understand that it is my responsibility to inform the dental office promptly of any changes in overall health or medical status.

Signature of Patient, Parent, or Guardian_____Date:_____

DENTAL HISTORY

What is the primary reason for your visit today? _____

Date of: Last Dental Visit _____ Last Dental Cleaning _____Last Full Mouth X-rays_____

Previous Dentist's Name:_____Phone:_____

Address:_____

How often do you have dental examinations? _____ How often do you brush your teeth?_____

How often do you floss?_____ What dental aids do you use? (Proxy brush, rinses, etc.)_____

Are any of your teeth sensitive to: Hot or cold? Y / N
Sweets? Y / N
Biting or chewing? Y / N

Do you notice any mouth odor or bad taste? Y / N

Do you frequently get cold sores or fever blisters? Y / N

Do your gums bleed or hurt? Y / N

Have your parents experienced gum disease or tooth loss? Y / N

Have you noticed any loose teeth or change in your bite? Y / N

Does food tend to become caught in your teeth? Y / N

If so, where?_____

Do you:

Clench or grind your teeth while awake? Y / N

Clench or grind your teeth while asleep? Y / N

Mouth breathe while awake or asleep? Y / N

Have tired jaws, especially in the morning? Y / N

Do you bite your fingernails? Y / N

Do you feel nervous about having dental treatment?

If so, what is your biggest concern? Y / N

_____

_____

Have you ever had:

Orthodontic treatment? Y / N

Oral surgery? Y / N

Periodontal treatment? Y / N

Your bite adjusted? Y / N

A bite plate or mouth guard? Y / N

A serious injury to the mouth? Y / N

If yes, describe_____

Have you ever experienced:

Clicking or popping of the jaw? Y / N

Joint, ear or side of face pain? Y / N

Difficulty in closing mouth? Y / N

Headaches, neck aches or shoulder aches? Y / N

Sore muscles? (neck or shoulders) Y / N

Are you satisfied with the appearance of your teeth? Y / N

If no, what would you like to change? _____

_____

Have you ever had an upsetting dental experience? Y / N

If so, please describe

_____

_____

Is there anything else about having dental treatment that you would like us to know?

_____

_____

FOR OFFICE USE ONLY

Reviewed by: _____ Date: _____

(Provider Signature)

DENTAL INSURANCE INFORMATION

Primary Insurance: Policy Holder Information	Secondary Insurance: Policy Holder Information
Policy Holder Name: _____ Relationship to Patient:_____ Date of Birth:_____SS#:_____ Insurance Company:_____ Ins. Co. Address:_____ Group#/Contract #:_____ Employer:_____ Employee ID #:_____	Policy Holder Name: _____ Relationship to Patient:_____ Date of Birth:_____SS#:_____ Insurance Company:_____ Ins. Co. Address:_____ Group#/Contract #:_____ Employer: _____ _____ Employee ID #:_____

AUTHORIZATION AND RELEASE

⇨ I authorize the dentist to release any information, including the diagnosis and any record of treatment or examination, rendered to be or my child during the period of such dental care to third-party payers and/or other health practitioners.

⇨ I authorize and request my insurance company to pay directly to the dentist any insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all the services rendered on my behalf or my dependents.

_____

Print Patient Name

_____Date:_____

Signature of patient or guardian

BRUSH DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This Notice takes effect 12/12/2002, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of his Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Print Patient Name:_____

has received a copy of this office's Notice of Privacy Practices.

_____

Signature Print Name

_____

Date

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to a file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Claudia