

WELCOME

BROOKFIELD DENTAL ASSOCIATES, PC

We would like to take this opportunity to welcome you and thank you for joining our dental practice. We appreciate your confidence in us and will do everything possible to provide you with the finest dental care. Please fill out this form completely. The better we communicate, the better we can care for you.

TODAY'S DATE: _____
Month Day Year

ABOUT YOU

Name: _____
Last First Middle Initial

I like to be called: _____

Home Address: _____

Apt./Condo # City State Zip Code

Is this also your mailing Address? YES NO

Social Security #: _____

Date of Birth: _____ Male Female

Single Married Divorced Widowed

Employer: _____

Occupation: _____ How long held: _____

Special interests, sports or hobbies: _____

Referred by: _____

TELEPHONE INFORMATION

Home Phone: _____

Work Phone: _____ Ext. #: _____

Beeper, Cell or Car Phone: _____

Where and when is the best time to reach you?

Spouse's Work Phone: _____

In the event of an emergency, is there someone that we can contact? YES NO

Name: _____

Relationship: _____

Phone number where this person can be reached at during business hours: _____

RELEASE INFORMATION

I hereby authorize the release of any dental information necessary to process my claims.

SIGNATURE: _____

ASSIGNMENT OF BENEFITS

I hereby authorize payment be made directly to Dr. Sonn of the dental group insurance otherwise payable to me.

SIGNATURE: _____

DENTAL BENEFITS

Do you have dental benefits through your employer?

YES NO

If yes, please provide us the following information:

Insurance Company Name: _____

Insurance Company Address: _____

Division

Street or Post Office Box

City State Zip Code

Insurance Company's Phone #: _____

Group #: _____

Your Employer's Name: _____

Employer's Address: _____

Do you have any other Dental Benefits Coverage?

YES NO

This coverage is through: Spouse Parent You

Name of Covered Person: _____

Their Employer: _____

Employer's Address: _____

City State Zip Code

Their Social Security #: _____

Their Date of Birth: _____

Month Day Year

Insurance Company's Name: _____

Insurance Company Address: _____

Division

Street or Post Office Box

City State Zip Code

Insurance Company's Phone #: _____

Group #: _____

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. WHEN SIGNING OVER BENEFIT PAYMENT, PATIENT IS RESPONSIBLE FOR THEIR PORTION AT THE TIME OF APPOINTMENT.

MEDICAL HISTORY

Personal Physician's Name: _____

Address: _____

Phone #: _____

Approximate date of your last visit: _____

Your current health is:
 GOOD FAIR POOR

Are you currently under the care of a physician?
 YES NO If yes, explain: _____

Do you smoke or chew tobacco?
 YES NO

Are you presently taking any drugs prescribed by a physician or dentist?
 YES NO If yes, please list drugs and dosage:

For women: Are you pregnant? YES NO

Do you need to be pre-medicated before dental treatment?
 YES NO If yes, explain: _____

Have you had any serious medical problems in the past?
 YES NO If yes, explain: _____

Have you ever had any of the following diseases or medical problems?

- | | |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack/Stroke | <input type="checkbox"/> Y <input type="checkbox"/> N Cancer/Chemotherapy |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur | <input type="checkbox"/> Y <input type="checkbox"/> N HIV+/AIDS |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Surgery | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chronic Hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N High/Low Blood Pressure | <input type="checkbox"/> Y <input type="checkbox"/> N Fever Blisters |
| <input type="checkbox"/> Y <input type="checkbox"/> N Severe Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy/Seizures/Fainting | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes |
| <input type="checkbox"/> Y <input type="checkbox"/> N Drug/Alcohol Abuse | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/Abnormal Bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease |

OFFICE USE ONLY: _____

Have you ever experienced any serious medical conditions not listed above?
 YES NO If yes, explain: _____

Are you allergic to any of the following drugs?

- | | |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Penicillin | <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin |
| <input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin | <input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N Codeine |

Are you allergic to latex? YES NO

Do you have any other allergies? YES NO If yes, please list: _____

DENTAL HISTORY

Why have you come to the dentist today? _____

Are you under any unusual stress at home or work?
 YES NO

Do you experience stress when you visit the dentist?
 YES NO

Approximate date of your last dental visit: _____

Approximate date of your last dental X rays: _____

Have you lost any teeth? YES NO

Have you experienced TMJ problems? YES NO

Do you grind your teeth? YES NO

Do your gums ever bleed? YES NO

Your current dental health is:
 GOOD FAIR POOR

Do you have any concerns about the appearance of your teeth?
 YES NO If yes, explain: _____

CANCELLATION POLICY

EXCEPT IN SEVERE WEATHER CONDITIONS OR IN EXTREME EMERGENCIES, A 24-HOUR NOTICE IS REQUIRED FOR CANCELLATION. OTHERWISE, PATIENTS WILL BE RESPONSIBLE FOR PAYMENT FOR THEIR APPOINTMENT, WHICH WILL BE CHARGED AT THE RATE OF \$50 PER ½ HOUR.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and that it is my responsibility to inform this office of any changes in my medical status.

SIGNATURE: _____

DATE: _____