WELCOME TO DR. BRINK'S OFFICE!!

Patient Information

Name_____ Birthdate_____ Home Phone_____
Address_____ City_____ State/Zip _____
Email _____ Cell Phone _____ Do you text? _____
Social Security Number _____
Patient's Employer _____ Work Number _____
How did you hear about our office? _____
Emergency Contact Person _____ Phone Number_____

Responsible Party

Name _____ Birthdate _____ Phone # _____
Address _____ City _____ State/Zip _____
Employer _____ Work Phone_____
Social Security Number _____ Cell Phone _____

DENTAL HISTORY

Name of previous dentist _____ Date of last exam? _____
Did you have x-rays taken? _____
Please put a check beside any of the following problems that apply to you:
__ Sensitivity to hot, cold or sweets __Tooth pain or discomfort when chewing
__Headaches, earaches, neck pain __Jaw joint pain
__Teeth or fillings breaking __Grinding or clenching teeth
__Bleeding, swollen or irritated gums __Loose, tipped or shifting teeth
__Bad breath or bad taste in your mouth __Trouble opening or closing
__Any lumps or sores in or near your mouth

Do you have or have you had any of the following?
__ Dentures __ Partials __Braces __ Periodontal (gum) treatments

Please share the following dates if possible

Your last cleaning _____ Your last complete x-rays _____

Have you had any difficult extractions in the past? _____
Have you ever had prolonged bleeding following an extraction? _____
Have you ever had orthodontic (braces) treatment? _____ Orthodontist's Name _____
If you could change your smile, you would: __make it brighter __make it straighter __
Close spaces__ Replace metal fillings with tooth colored ___ repair chipped teeth ___
Replace missing teeth ___ replace old crowns ___ (Check all that apply)

Do you have a **LATEX** allergy? _____

Patient's Medical History

HAVE YOU TRAVELED OUTSIDE THE US WITH IN THE LAST 21 DAYS? _____
IF SO, DO YOU HAVE ANY RESPIRATORY SYMPTOMS OR FEVER? _____

Physician's Name _____ Phone number_____
Are you taking any medications either prescription or non- prescription? Yes or No, if yes, please list
_____
Have you ever taken Fosamax, Boniva, Actonel , Reclast or any infusion for osteoporosis or any other bisphosphonates? Yes_____ No____
Are you allergic or have you had a reaction to any of the following?
Local Anesthetics Yes_____ No_____
Penicillin Yes_____No_____
Other Antibiotics Yes_____No_____ If so, please list_____
Allergy to Metal? (eg: Nickel, mercury , etc.) Yes_____ No_____
Are you on any blood thinners? Yes_____ No_____
Do you have a LATEX Allergy? Yes_____ No_____
Women Only:
Are you pregnant or think you may be? Yes_____ No_____
Are you nursing? Yes_____ No_____
Are you taking oral contraceptives? Yes_____ No_____

Have you had or ever been treated for: Check all that apply.

High Blood Pressure____	Heart Disease___	Heart Attack___
Rheumatic Fever___	Asthma ___	Low Blood Pressure___
Epilepsy ___	Convulsions ___	Diabetes ___
Aids or HIV ___	Pacemaker___	Heart Murmur ___
Cancer ___	Hepatitis ___	Stroke ___
Joint Replacement___	A-FIB ___	Stomach Troubles ___
Radiation Therapy ___	Chemotherapy ___	
Mitral Valve Prolapse ___	Skin Rash ___	

Do you need to take a premedication for dental treatment? If so, for what condition
_____

Are you nursing? Yes_____ No_____
Are you taking oral contraceptives? Yes_____ No_____
The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X_____
Signature of patient or parent/guardian if minor Date

FINANCIAL AND INSURANCE RESPONSIBILITY

Patient's Name: _____ Date of Birth: _____
Address _____
Dental Insurance Carrier: _____
Secondary Dental Insurance Carrier : _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group 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 services rendered on my behalf or my dependents. All fees are due at the time services are rendered; insurance will be filed to reimburse the patient. I understand that I am responsible for any unpaid balance not paid by the insurance, and cost of collection, including but not limited to attorney fees. We do accept payment from insurance company, however we are not contracted with them. It is a contract between you, your employer and insurance company. The only insurance company we are contracted with is Delta Dental Premier, however, you still may have out of pocket expense for co-pays and deductibles, due when services are rendered.

Divorced/Single Parents: Payment is due on the day of service by the parent who accompanies the child to our office. We will file insurance for you if the child has coverage, but you are responsible for any deductibles or co- payments at the time of visit. If the insurance company pays the member directly, we will still submit for you, but you must pay for today's visit in full. Payment for today's visit and future visits is due at the time of treatment.

We request 48-hour cancellation notice for scheduled appointments. A cancellation fee of $50.00 may be charged if a 48-hour notice is not given.

We do not have the ability to set up payment plans. We do offer financing through Care Credit. We also accept all major credit cards, cash and checks. Your estimated out of pocket expense is due the day services are rendered. All treatment plans are an estimate.

_____

Patient /Responsible Party Signature Date