LET'S GET AQUAINTED

PATIENT INFORMATION: Date: / /

Name: _____ Goes By: _____
Address: _____ City, State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Sex: M / F Marital Status: S / M/ D/ W Spouse Name: _____
SS#: _____ DOB: _____ Driver's License #: _____
Referred to office by: _____ Preferred Pharmacy: _____
EMAIL: _____ Emergency Contact _____

Do you have dental insurance? Y / N Insurance Company: _____
Subscriber Name: _____ ID# _____ DOB _____

ACCOUNT INFORMATION: *(Responsible person for patient, if different from above)*

Name: _____ Relationship to patient: _____
Address: _____ City, State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
SS#: _____ DOB: _____ Driver's License #: _____

HEALTH HISTORY:

What dental problems are you having today? _____
When did you last visit a dentist? _____
Are your teeth sensitive to hot, cold, or sweets? Y / N / Sometimes
Do your gums bleed when brushing? Y / N / Sometimes

Please circle any of the following that apply:

Heart Murmur	Anemia	Hepatitis	Heart Trouble
Mitral Valve Prolapse	Diabetes	Cancer	HIV / AIDS
Artificial Joints	Arthritis	V.D. / S. T. D.	Abnormal Bleeding / Surgery
Rheumatic Fever	Headaches	X-ray Therapy	Psychiatric Treatment
Breast Augmentation	High / Low BP	Epilepsy	Respiratory Disease
Tuberculosis	Asthma	Glaucoma	Sinus Prob's

Are you pregnant now? Y / N # of months? _____
Any other health problems? _____
Please list any medications you are ***ALLERGIC TO***: _____
_____
Please list any *prescription medications* you are presently taking: _____
_____

I give my permission to Dr. Brad Brooks and staff to provide dental care and anesthesia as needed.

_____ _____
Patient Signature Guardian Signature (if minor)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES.

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

_____
(print name)

_____
(signature)

Insurance Release- *If you have dental insurance please sign in all three places below.*

I have reviewed and/or been advised of the accompanying treatment, and I hereby authorize the release of any medical information necessary for the processing of this dental claim.

_____
(signature)

I hereby request assignment of my dental benefits to the dental services provider indicated below.

_____
(signature)

I understand that my portion of my dental treatment will be paid at or before the time of service. If the insurance does not pay on any procedure, for any reason, or does not pay the full amount expected, I am responsible for this amount, in full, due upon receipt of statement. I also understand that if insurance has not paid within 90 days I will be billed for this amount, due upon receipt of statement, and that I will be responsible for getting reimbursed by my insurance company.

_____
(signature)

NAME & ADDRESS OF ATTENDING DENTIST:

BRAD BROOKS, DDS, License 16481
5301 50th St., Suite 200
Lubbock, Tx. 79414
(806)792-2759