Welcome

BRILLA DENTAL GROUP
Sonríe, La Vida Es Buena

1 ABOUT YOU

Today's Date____/____/____

Patient's Last Name _____

Patient's First Name _____

What do you prefer to be called? _____

Mailing Address_____

_____
City State Zip

How did you learn about our office? [ ]TV [ ]Radio [ ]Coupon
[ ]Friend/Family: _____ [ ]other:_____

WHAT IS THE **BEST** WAY TO CONTACT YOU:
[ ]Home phone [ ]Cell phone [ ]Work phone [ ]Email

Home Phone # _____

Cell Phone # _____

Work Phone # _____

E-mail Address_____

Birth Date ____/____/____ Age____ SS #_____

Employer _____How long?_____

Preferred Language: [ ] Spanish [ ] English

2 DENTAL INSURANCE

Do you have Dental Insurance [ ]Yes [ ]No

Primary Insurance_____

Policy Subscriber's Name_____

Relation_____ Birth Date ____/____/____

Subscriber's ID# or S.S.#_____

Subscriber's Employer_____

Phone # _____

Secondary Insurance _____

Subscriber's ID# or S.S.# _____

Subscriber's Employer_____

Phone #_____

3 FINANCIAL ACCOUNT INFORMATION

Person ultimately responsible for the account:
[ ] Self
[ ] Other: Name _____Relation_____

Billing Address_____

_____
City State Zip

Home Phone # _____

Cell Phone # _____

Work Phone # _____

E-mail Address_____

SS #_____Driv. Lic. #_____

Intended Payment Method:
[ ]cash [ ]check [ ]CareCredit [ ]Financing [ ]credit card

- I have had full opportunity to read and consider the contents of the complete Financial Policy of Brilla Dental Group
- I hereby authorize assignment of my insurance rendered.
- I am solely responsible for any balance not paid by my insurance.
- I know that Payment-in-full is due at time of visit, unless other arrangements have been made.
- I authorize release of information required to process claims.
- I know that a $45 fee will be incurred for any returned check.
- I am aware that if my account is not paid within 90 days that I will be responsible for all fees and charges incurred in collecting.
- I am aware that failing to cancel & not showing up for an appointment may incur a a min. of $50 *per hr. to a max. $200* "No-Show" Fee.
- I am aware that requests for duplicate x-rays must accompany the designated fee.

Signature_____**Date:**_____

4 IN THE EVENT OF AN EMERGENCY

Whom should we contact:

Name_____

Relation_____

Home Phone #_____

Work Phone # _____

Cell Phone #_____

Medical Doctors Name_____

Phone #_____

Other Person (if any) you authorize us to discuss your care or treatment with:

_____

5 The Health Insurance Portability and Accountability Act (HIPAA)

I have had full opportunity to read and consider the contents of this office's *Notice of Privacy Practices*. I understand that, by signing this form, I am giving my consent to the use and disclose any of my health information to carry out treatment, payment activities, and healthcare operations.

Signature_____**Date:** _____

Representative completing the consent on behalf of the patient:

Name_____Relationship_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT UPON REQUEST and MAY REQUEST A COPY OF OUR NOTICE OF PRIVACY PRACTICES. YOU MAY REVOKE THIS CONSENT AT ANY TIME.

6

Reason for today's visit: [ ] Exam [ ] Emergency [ ] Consultation
Are you in pain? [ ]No [ ]Yes How Long? _____
Is this your first time to a dentist? [ ]Yes [ ] No:
Previous Dentist: _____ (____) _____
Name Phone
Last Dental Exam:____________ Last Dental X-rays:____________
Do you require pre-medication? [ ]No [ ]Yes [ ]Don't know
Are you allergic to any of the following: [ ] Latex [ ] Penicillin / Amoxicillin [ ] Tetracycline [ ] Aspirin
[ ] Dental Anesthetics [ ] Foods:_____ [ ] Others:_____
Times per day you brush:_____ Times a week you floss:_____
What type of tooth brush bristles do you use? [ ] Soft [ ] Medium [ ] Hard

7 DENTAL CONCERNS

Please indicate any of the following you would like to speak to the doctor about:

[ ] Discomfort, clicking or popping in jaw
[ ] Red, swollen or bleeding gums
[ ] Sensitive tooth, teeth or gums
[ ] Blisters/Sores in or around the mouth
[ ] Missing teeth
[ ] Proper dental hygiene: brushing/flossing
[ ] Lost/Broken Filling(s)
[ ] Teeth grinding
[ ] Ringing in ears
[ ] Broken/Chipped tooth
[ ] "Gummy" smile showing too much gum tissue
[ ] Stained/Yellow Teeth
[ ] Locking jaw
[ ] Bad breath
[ ] Crooked teeth
[ ] Other: _____

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

8 MEDICAL HISTORY

What medications are you taking? [ ] Nerve pills [ ] Pain killers (including aspirin) [ ] Insulin
[ ] Muscle relaxers [ ] Stimulants [ ] Blood Thinners [ ] Tranquilizers [ ] Meds for Osteoporosis
[ ] Other(s), please list_____

Have you ever taken: Bisposphonates (ex:Aredia/Fosamax) [ ]Yes [ ]No Phen-fen/Redux [ ]Yes [ ]No

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	Y N Thyroid Problems	Y N Cancer/Tumors	Y N Cholesterol
Y N Heart Surg./ Pacemaker	Y N Kidney Problems	Y N Xray or Cobalt Treatment	Y N Shingles
Y N Heart Murmur	Y N Liver Problems	Y N Diabetes/Hypoglycemia	Y N Chemotherapy
Y N Rheumatic Fever	Y N Respiratory Problems	Y N HIV+/AIDS/ARC	Y N Asthma
Y N Mitral Valve Prolapse	Y N Sinus Problems	Y N Arthritis / Rheumatism	Y N Difficulty Breathing
Y N Artificial Valves	Y N Stomach Problems/Ulcers	Y N Artificial Bones/Joints	Y N Hepatitis
Y N Congenital Heart Defect	Y N Psychiatric Problems	Y N High/Low Blood Pressure	Y N Leukemia
Y N Chest Pains	Y N Alcohol/Drug Abuse	Y N Severe/Frequent Headaches	Y N Emphysema
Y N Scarlet Fever	Y N Tuberculosis TB	Y N Frequent Neck Pain	Y N Bleeding Problems
Y N Nervousness	Y N Jaw Problems TMJ/TMD	Y N Back Problems	Y N Glaucoma

Please list any other surgeries or medical conditions you have or ever had: _____

_____

Do you use tobacco? [ ]No [ ]Yes/How used: _____ How much:_____ How long:_____

Please rate your general health from 1-10:_____ Do you wear contact lenses? [ ]Yes [ ]No

For women: Are you taking Birth Control pills? [ ]Yes [ ]No How many children have you had?_____

Are you Pregnant? [ ]No [ ]Yes/How long?_____ Are you nursing? [ ]Yes [ ]No