dr. bryan b.

bruinsdentist.com

Welcome!

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ☐ M ☐ F Age_____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Who may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____

Primary Insurance

Subscriber Name _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address *(If different from patient)* _____ Home Phone _____

City _____ State _____ Zip _____ Business Phone _____

Subscriber Employed by _____ Occupation _____

Business Address _____

Insurance Company _____ Phone _____

_____

Contract # _____ Group # _____ Subscriber # _____

Dental History

What would you like us to do today? _____ Are you in any dental discomfort? _____

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Yes ☐ No

Other information about your dental health or previous treatment _____

Medical History

Physician's name _____ Phone _____

Date of last visit _____ Have you ever had any serious illness or operations? ☐ Yes ☐ No

If yes, describe _____

Are you currently under physician care? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

Women: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) yes or no whether you have had any of the following:

☐ Y ☐ N AIDS/HIV Positive	☐ Y ☐ N Cough, persistent	☐ Y ☐ N Jaw pain	☐ Y ☐ N Shingles
☐ Y ☐ N Anaphylaxis	☐ Y ☐ N Cough up blood	☐ Y ☐ N Kidney disease or malfunction	☐ Y ☐ N Shortness of breath
☐ Y ☐ N Anemia	☐ Y ☐ N Diabetes		☐ Y ☐ N Skin rash
☐ Y ☐ N Arthritis, Rheumatism	☐ Y ☐ N Epilepsy	☐ Y ☐ N Liver disease	☐ Y ☐ N Spina Bifida
☐ Y ☐ N Artificial heart valves	☐ Y ☐ N Fainting	☐ Y ☐ N Material allergies (**latex**, wool, metal chemicals)	☐ Y ☐ N Stroke
☐ Y ☐ N Artificial joints	☐ Y ☐ N Food allergies		☐ Y ☐ N Surgical implant
☐ Y ☐ N Asthma	☐ Y ☐ N Glaucoma	☐ Y ☐ N Mitral valve prolapse	☐ Y ☐ N Swelling of feet or ankles
☐ Y ☐ N Atopic (allergy prone)	☐ Y ☐ N Headaches	☐ Y ☐ N Nervous problems	
☐ Y ☐ N Back problems	☐ Y ☐ N Heart murmur	☐ Y ☐ N Pacemaker/ Heart Surgery	☐ Y ☐ N Thyroid disease or malfunction
☐ Y ☐ N Blood disease	☐ Y ☐ N Heart problems Describe _____		
☐ Y ☐ N Cancer		☐ Y ☐ N Psychiatric care	☐ Y ☐ N Tobacco habit
☐ Y ☐ N Chemical dependency	☐ Y ☐ N Hemophilia/ Abnormal bleeding	☐ Y ☐ N Rapid weight gain or loss	☐ Y ☐ N Tonsillitis
☐ Y ☐ N Chemotherapy		☐ Y ☐ N Radiation treatment	☐ Y ☐ N Tuberculosis
☐ Y ☐ N Cortisone treatments	☐ Y ☐ N High blood pressure	☐ Y ☐ N Rheumatic/Scarlet fever	☐ Y ☐ N Venereal disease

Is patient currently taking any medications? If yes, list all:

_____

_____

Does patient have drug allergies? If yes, list all:

_____

_____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

Dr. Bryan Hoertdoerfer, DDS

4 Elliot Way Suite 306 Manchester, NH 03103
603-669-1251

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry our treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to the Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include complete Consent in the patient's chart.