



# Medical History

Although our dental personnel primarily treat the area in and around the mouth, your mouth is still part of the overall body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_

Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_

Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_

Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No \_\_\_\_\_

Are you on a special diet?  Yes  No

Do you use tobacco or a vape pen?  Yes  No

Do you use controlled substances?  Yes  No

Do you use marijuana of any kind?  Yes  No

Women: Are you  
 Pregnant/Trying to become pregnant?  Yes  No    Taking oral contraceptives?  Yes  No    Nursing?  Yes  No

Are you allergic to any of the following?  
 Aspirin     Penicillin     Codeine     Local Anesthetics     Acrylic     Metal     Latex  
 Sulfa     Other    If yes, please explain: \_\_\_\_\_

Do you have, or have you had, any of the following? Please circle yes (Y) or no (N) for all answers.

AIDS/HIV Positive	Y N	Diabetes	Y N	Hepatitis B or C	Y N	Renal Dialysis	Y N
Alzheimer's Disease	Y N	Drug Addiction	Y N	Herpes	Y N	Rheumatic Fever	Y N
Anaphylaxis	Y N	Easily Winded	Y N	High Blood Pressure	Y N	Rheumatism	Y N
Anemia	Y N	Emphysema	Y N	High Cholesterol	Y N	Scarlet Fever	Y N
Angina	Y N	Epilepsy	Y N	Hives	Y N	Shingles	Y N
Arthritis/Gout	Y N	Excessive Bleeding	Y N	Hypoglycemia	Y N	Sickle Cell Disease	Y N
Artificial Heart Valve	Y N	Excessive Thirst	Y N	Intestinal Disease	Y N	Sinus Trouble	Y N
Artificial Joint	Y N	Fainting Spells	Y N	Irregular Heartbeat	Y N	Spina Bifida	Y N
Asthma	Y N	Frequent Cough	Y N	Kidney Problems	Y N	Stomach Disease	Y N
Blood Disease	Y N	Frequent Diarrhea	Y N	Leukemia	Y N	Stroke	Y N
Blood Transfusion	Y N	Frequent Headaches	Y N	Liver Disease	Y N	Swelling of Limbs	Y N
Breathing Problem	Y N	Genital Herpes	Y N	Low Blood Pressure	Y N	Thyroid Disease	Y N
Bruise Easily	Y N	Glaucoma	Y N	Lung Disease	Y N	Tonsillitis	Y N
Cancer	Y N	Hay Fever	Y N	Mitral Valve Prolapse	Y N	Tuberculosis	Y N
Chemotherapy	Y N	Heart Attack	Y N	Osteoporosis	Y N	Tumors or Growths	Y N
Chest Pains	Y N	Heart Disease	Y N	Pain in Jaw Joints	Y N	Ulcers	Y N
Cold Sores	Y N	Heart Murmur	Y N	Parathyroid Disease	Y N	Venereal Disease	Y N
Congenital Heart Disease	Y N	Heart Pacemaker	Y N	Psychiatric Care	Y N	Yellow Jaundice	Y N
Convulsions	Y N	Hemophilia	Y N	Radiation Treatments	Y N		
Cortisone Medicine	Y N	Hepatitis A	Y N	Recent Weight Loss	Y N		

Comments: \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform Brookside Dental Care staff of any changes in medical status.

**X** \_\_\_\_\_  
 Signature of patient, parent, or guardian

**Date:** \_\_\_\_\_

## Insurance Information

### Primary Insurance

Dental Insurance Company Name: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

Is the Policy Holder a patient?  Yes       No

Policy Holder's Date of Birth: \_\_\_\_\_ Policy Holder's Employer: \_\_\_\_\_

Policy Holder's ID# \_\_\_\_\_ Group # \_\_\_\_\_

Patient's relationship to the Policy Holder:  Self       Spouse       Child       Other: \_\_\_\_\_

### Secondary Insurance

Dental Insurance Company Name: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

Is the Policy Holder a patient?  Yes       No

Policy Holder's Date of Birth: \_\_\_\_\_ Policy Holder's Employer: \_\_\_\_\_

Policy Holder's ID# \_\_\_\_\_ Group # \_\_\_\_\_

Patient's relationship to the Policy Holder:  Self       Spouse       Child       Other: \_\_\_\_\_

**Please be aware that we collect estimated insurance portions at each visit.** Your insurance policy is a contract between you and your insurance company. You are responsible for any unpaid balances, regardless of the original estimate of insurance benefit. As a courtesy to you, we will file your claims with your insurance company. Insurance payments are normally received within 30 to 45 days. **Any unpaid balances after 60 days are your responsibility and are due at that time. All deductibles and co-payments are due at the time of service.** A completed claim form or copy of your insurance card will need to be kept on file in our office. We try to answer any questions you may have about your insurance company. However, you may need to contact your insurance company for additional information. **If your insurance changes, it is your responsibility to provide updated information to our office.**

**Assignment of Benefit:** Please read and sign to have our office file your insurance:

I authorize the release of information and understand that I am responsible for all costs of dental treatment. I hereby authorize payment directly to Brookside Dental Care, LTD. of the insurance benefits otherwise payable to me.

X \_\_\_\_\_  
Signature of patient, parent, or guardian

Date: \_\_\_\_\_

## **Billing Policy, Consent for Treatment and Payment**

**Payment is expected at time of service.** We accept cash, check, money order, Visa, Discover, MasterCard, Cherry, CareCredit, and most forms of contactless payments. Returned checks are subject to a \$50.00 fee. Aged balances over 90 days, regardless of insurance, are subject to a finance charge of \$20.00 per month. If you have a past due balance and wish to receive service, you will be required to pay the past due balance and the new charges at time of service.

### **FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:**

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for and by members of my family shown by statements, promptly upon presentation thereof. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within 30 days of billing date. In event legal action should become necessary to collect an unpaid balance due for medical services rendered to my family or me, I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper. It is agreed that all payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original.)

**NOTICE:** Do not sign this agreement before you read and agree to the conditions set forth. You are entitled to a copy of this agreement at the time you sign. Keep it to protect your legal rights.

**AGREEMENT:** The above information is for the purpose of obtaining credit and is warranted to be true. I authorize the creditor or his agent to make a credit investigation, including employment verification. I hereby acknowledge receipt of a copy of this form.

**X** \_\_\_\_\_  
Signature of patient, parent, or guardian

**Date:** \_\_\_\_\_

