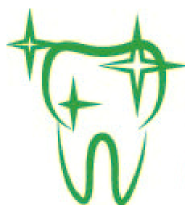
Welcome!



PATIENT NAME: ______________________________ **DOB:** ________________________

STREET ADDRESS: _______________ **CITY:** ____________ **STATE:** _____ **ZIP:** ______

CELL PHONE: _____________________ **WORK /OTHER PHONE:** ________________

EMAIL: ___________________@____________

Married **Single** **Spouse Name/Number:** _________________________________

SSN (for insurance)**:** ____________ **DL#** (for checks)**:** _____________ **EMPLOYER:** __________

OCCUPATION: ___________ **Whom may we thank for referring you?** ____________

DENTAL INSURANCE: ______________________ **PHONE:** _______________________

GROUP# ____________________________ **POLICY #** _______________________________

POLICY HOLDER'S NAME: ____

SECONDARY INSUR: _________________ **GROUP#** _____________ **POLICY#** __________

PLEASE ANSWER EACH QUESTION (CIRCLE YES OR NO)

YES NO Have you been under the care of a physician in the past 2 years?
For what purpose? ________________________ **Physician's name:** ____________

YES NO Have you taken any medications during the past year?
Please list: ____

YES NO Are you allergic to penicillin?

YES NO Are you allergic to any other drug or medication?
Please list: ____

YES NO Have you ever had excessive bleeding that required special treatment?

YES NO Have you ever taken pre-medication prior to dental treatment?

YES NO Do you take blood thinners? List: _________________________________

YES NO Have you ever taken Fosamax or a bisphosphonate drug?

YES NO Do you currently or have you ever used tobacco? What type? _________

Your Physical health is: Good Fair Poor - Please Explain: ________________________

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD:

Heart Trouble/Attack	**Hepatitis Rheumatic Fever**	**Osteoporosis**
HIV/AIDS	**Heart Valve Defect**	**Prosthetic Joints**
Diabetes	**Sinus Trouble**	**Asthma**
Heart Murmur	**Tuberculosis**	**Low Blood Pressure**
High Blood Pressure	**Cancer**	**Anemia/Liver Disease**
Arthritis	**Epilepsy-Under Treatment?**	**Radiation**
Stroke-When? _________	**How Severe?** ______________	**Other:** ______________________

If you have any of these, please explain: ____

TURN PAGE OVER PLEASE

Dr's Notes:____

YES NO (Women) Are you pregnant or breastfeeding? Due Date:____________

In Case of Emergency who should be notified?________________________

Phone number: ___________________ **Relation?**______________________

When was your last dental exam and cleaning? _______________**X-rays?**______

Purpose of today's appointment?_____________________________________

How did you hear about our practice? Friend Newspaper Website Facebook Other

I hereby authorize Dr. James Brummett DMD and/or legally qualified auxiliaries/associates to administer treatment and local anesthetics(numbing) as may be deemed necessary or advisable in the diagnosis and treatment of me (or my children if I, as a parent, have left them in the dentist's care). I understand I will always be consulted before treatment is rendered. All questions have been answered truthfully and in my own hand.
Signature:___________________________ **Date:**__________________________

Patient Financial Responsibility:

Name of responsible party (if other than self):_____________________________________

Relationship to patient:______________Phone number (cell/work/home):__________________

Please read and ask the front desk any questions:

I certify that I have read and understand the above information to the best of my knowledge. I authorize James C. Brummett, DMD, PLLC to release any information including the diagnosis and records of any treatment or exam rendered to me or my dependent to my insurance company, other health providers when referred out of this office, or authorized party listed below. This may be done electronically via secure internet connections. I authorize my insurance to pay directly to the dentist / assign benefits. I understand that **my dental insurance carrier may pay less** than the actual bill for my services. **I agree to be responsible for the payment of all services rendered** on my behalf or my dependents. **I understand payment is due at the time of service** and in case of default I will be responsible for reasonable attorney's fees and all costs of collections. Payment default (non-payment) will be processed in accordance with the State Attorney's Office of Florida and/or the county court system. I, the patient, have read and fully understand the Privacy Act Notices of James C. Brummett, D.M.D., PLLC and agree and consent to this policy, (see clipboard, ask for a personal copy if needed).

Signature of Patient or Guardian: _________________________Date:__________________________
HIPAA release to **specific individuals (Spouse, Adult Children, Caretaker):**
I authorize the office of James C. Brummet, DMD, PLLC to share/discuss my dental/health records or appointment information with the following individuals:______________________________

Signature:__________________________________Date:__________________________________