# Welcome to our Practice

## PATIENT INFORMATION:

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. First Name_____ Last Name_____

Sex: ☐ Male ☐ Female Birth Date_____ Age_____ Soc. Sec.#_____ Email_____

Street_____ Apt_____ City_____ State_____ Zip_____

Home Tel. (_____)_____ Cell (_____)_____ Have you ever been a patient at our practice? ☐ Yes ☐ No

Referred by_____ _____ Has a family member ever been a patient of our practice? ☐ Yes ☐ No
FIRST NAME LAST NAME

Employer_____ Bus. Tel. (_____)_____

Nearest relative not living with you _____ _____ Tel. (_____)_____
FIRST NAME LAST NAME

In case of emergency, please contact _____ Tel. (_____)_____Relation _____

Driver's Lic. #_____

## WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

☐ Self (If self, skip this section) ☐ Spouse ☐ Father ☐ Mother ☐ Other_____

Name_____ _____ S.S.#_____ D-O-B_____ Age_____
FIRST NAME LAST NAME

Home Tel. (_____)_____ Cell (_____)_____ Email_____

Street_____ Apt_____ City_____ State_____ Zip_____

Driver's Lic. #_____ Employer_____ Bus. Tel. (____)_____

## SPOUSE OR OTHER GUARANTOR INFORMATION: *(IF DIFFERENT FROM ABOVE)*

Name_____ _____ Relation _____S.S.#_____ D-O-B_____ Age_____
FIRST NAME LAST NAME

Street_____ Apt_____ City_____ State_____ Zip_____

Tel. (_____)_____ Employer_____ Bus. Tel. (____)_____

## INSURANCE INFORMATION:

**Student:** ..... ☐ Full Time ☐ Part Time ☐ Not..... School Name_____ Address_____

**Marital Status:** . ☐ Married ☐ Divorced ☐ Widow ☐ Single ☐ Legally Separated

**Employed:**..... ☐ Full Time ☐ Part Time ☐ Not

**Dr. Elizabeth Brennan** - 1408 Egypt Road - PO Box 402 - Oaks, PA 19456 - (610) 666-5118

OAKS FAMILY DENTAL

## PRIMARY DENTAL INSURANCE COMPANY:

Employer_____ Bus. Tel. (_____)_____

Bus. Address_____ _____ _____ _____
ADDRESS CITY STATE ZIP

Ins. Co. Name_____ Plan_____ I.D.#_____

Address_____ _____ _____ _____
ADDRESS CITY STATE ZIP

Tel. (____)_____ Group Name _____ Group #_____

Insured Party_____ _____
FIRST NAME LAST NAME

Relation_____ D-O-B_____ Sex ☐ M ☐ F

S.S. # _____ Tel. (____)_____

Address_____ _____ _____ _____
ADDRESS CITY STATE ZIP

## SECONDARY DENTAL INSURANCE COMPANY:

Employer_____ Bus. Tel. (_____)_____

Bus. Address_____ _____ _____ _____
ADDRESS CITY STATE ZIP

Ins. Co. Name_____ Plan_____ I.D.#_____

Address_____ _____ _____ _____
ADDRESS CITY STATE ZIP

Tel. (____)_____ Group Name _____ Group #_____

Insured Party_____ _____
FIRST NAME LAST NAME

Relation_____ D-O-B_____ Sex ☐ M ☐ F

S.S. # _____ Tel. (____)_____

Address_____ _____ _____ _____
ADDRESS CITY STATE ZIP

### FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure you may require will be given to you upon request. If you have any dental insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.
Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorney fees, and court costs.

**X** _____ **X** _____ **X** _____
**Signature of patient** *(Parent or Guardian if Minor)* **Reviewed by** **Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

**X**_____**X**_____
**Signature of patient** *(Parent or Guardian if Minor)* **Date**

## HEALTH HISTORY:

**To our patients:** Although Dentists primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Reason for today's office visit? _____

| | Yes | No |
|---|---|---|
| 1. Have there been any changes in your general health in the last year? | ☐ | ☐ |
| 2. Are you under the care of a physician? | ☐ | ☐ |
| a. Physician Name:_____ | | |
| b. Phone:_____ | | |
| c. **What are you being treated for**_____ | | |
| 3. Have you had any illness, operation, or been hospitalized in the past five (5) years? | ☐ | ☐ |
| a. **If yes, describe**_____ | | |
| 4. Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth? | ☐ | ☐ |
| a. **If yes, describe**_____ | | |
| 5. Do you have a prosthetic joint / implant? | ☐ | ☐ |
| a. **If yes, describe**_____ | | |
| 6. Have you had a heart valve replacement or vascular graft? | ☐ | ☐ |
| 7. Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? | ☐ | ☐ |

| HAVE YOU HAD, OR DO YOU CURRENTLY HAVE: | YES | NO | NOTES |
|---|---|---|---|
| 8. Rheumatic fever? | | | |
| 9. Damaged or artificial heart valves / mitral valve prolapse? | | | |
| 10. Heart murmur? | | | |
| 11. High blood pressure? | | | |
| 12. Low blood pressure? | | | |
| 13. Chest pain / angina? | | | |
| 14. Heart attack(s)? | | | |
| 15. Irregular heart beat? | | | |
| 16. Chronic Heart Failure? | | | |

| HAVE YOU HAD, OR DO YOU CURRENTLY HAVE: | YES | NO | NOTES |
|---|---|---|---|
| 17. Chronic cough? | | | |
| 18. Asthma? | | | |
| 19. Hay fever / sinus problems? | | | |
| 20. Snoring / Sleep Apnea? | | | |
| 21. Difficulty breathing / other lung trouble? | | | |
| 22. Osteonecrosis? | | | |
| 23. Swollen ankles / arthritis / point disease? | | | |
| 24. Osteoporosis / osteopenia? | | | |
| 25. Tuberculosis? | | | |

| HAVE YOU HAD, OR DO YOU CURRENTLY HAVE: | YES | NO | NOTES |
|---|---|---|---|
| 26. Blood disorder? | | | |
| 27. Hay fever / sinus problem? | | | |
| 28. Cardiac pacemaker? | | | |
| 29. Heart surgery, or other heart condition? | | | |
| 30. Pneumonia, bronchitis? | | | |
| 31. Bleeding tendency / abnormal bleeding? | | | |
| 32. Hepatitis, jaundice, or liver disease? | | | |
| 33. Artificial joint? | | | |
| 34. Gallbladder trouble? | | | |
| 35. Fainting spells? | | | |
| 36. Convulsions / epilepsy? | | | |
| 37. Stroke? | | | |
| 38. Thyroid trouble? | | | |
| 39. Diabetes? | | | |
| 40. Low blood sugar? | | | |
| 41. Kidney trouble? | | | |
| 42. Are you on dialysis? | | | |
| 43. Stomach ulcers / acid reflux? | | | |
| 44. Sexually transmitted diseases? | | | |
| 45. Chest pain / angina? | | | |

| HAVE YOU HAD, OR DO YOU CURRENTLY HAVE: | YES | NO | NOTES |
|---|---|---|---|
| 46. Emphysema? | | | |
| 47. Do you use chewing tobacco? | | | |
| 48. Blood transfusion? | | | |
| 49. Do you smoke? If yes, number of packs per day_____ | | | |
| 50. Bruise easily? | | | |
| 51. Delay in healing? | | | |
| 52. Problems with immune system? Possibly from medication / surgery, etc. | | | |
| 53. A tumor or growth? | | | |
| 54. Cancer - radiation/chemotherapy? | | | |
| 55. Chronic fatigue / night sweats? | | | |
| 56. Are you on a diet / recent weight loss? | | | |
| 57. A history of alcohol abuse? | | | |
| 58. A history of drug abuse? | | | |
| 59. Tonsillitis? | | | |
| 60. Eye disease / glaucoma? | | | |
| 61. Mental health problems/anxiety/depression? | | | |
| 62. Are you on psychiatric care? | | | |
| 63. Alzheimer's disease? | | | |
| 64. Anaphylaxis | | | |
| 65. Shingles? | | | |

**WOMEN ONLY:** *(QUESTIONS 66–69)*

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| 66. Is there a possibility of pregnancy? | ☐ | ☐ | 68. Are you nursing? | ☐ | ☐ |
| 67. Expected delivery date? _____ | | | 69. Are you taking birth control pills? | ☐ | ☐ |

| ARE YOU NOW TAKING: | YES | NO | NOTES |
|---|---|---|---|
| 70. Any kind of medication, drug, pills? | | | |
| 71. Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Pradaxa, Fish oil? | | | |
| 72. Have you ever taken diet pills? | | | |
| 73. Any natural product, herbal supplement or homeopathic remedy? | | | |

| ARE YOU ALLERGIC TO, OR HAD A REACTION TO: | YES | NO | NOTES |
|---|---|---|---|
| 74. Local anesthetic (numbing meds.)? | | | |
| 75. Penicillin? | | | |
| 76. Other antibiotics? | | | |
| 77. Sulfa drugs? | | | |

| ARE YOU NOW TAKING: | YES | NO | NOTES |
|---|---|---|---|
| 78. Are you taking, or have you ever taken, bone density meds. or bisphosphonates such as Fosamax, Boniva, Actonel, IV-Zometa, Aredia, or Reclast in the past 12 years? | | | |
| 79. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If yes, please list: | | | |
| | | | |
| 80. Please list any medications you are currently taking: \| Medication \| Dosage \| Frequency \| | | | |
| | | | |
| Is there any condition concerning your health that the Doctor should be told about? ☐ Yes ☐ No – If yes, describe | | | |
| Do you wish to speak with the Doctor privately about anything? ☐ Yes ☐ No | | | |

| ARE YOU ALLERGIC TO, OR HAD A REACTION TO: | YES | NO | NOTES |
|---|---|---|---|
| 81. Sodium pentothal / Valium / other tranquilizers? | | | |
| 82. Aspirin? | | | |
| 83. Amoxicillin? | | | |
| 84. Codeine or other narcotics? | | | |
| 85. Other medications? | | | |
| 86. Latex? | | | |
| 87. Metals? | | | |
| 88. Acrylic? | | | |
| 89. Sulfites? | | | |
| 90. Do you have any known allergies? | | | |
| 91. Please list any allergies other than drug allergies? | | | |
| Is there a family history of: ☐ Cancer ☐ Diabetes ☐ Heart disease | | | |

**Consent for Treatment/X-rays:** I authorize my Dentist and his/her designated staff, to perform oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers.

**X** _____ **X** _____ **X**_____**X**_____

**Signature of patient** *(Parent or Guardian if Minor)* **Witness** **Doctor** **Date**

**I certify** that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my Dentist, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

**X** _____ **X** _____ **X** _____

**Signature of patient** *(Parent or Guardian if Minor)* **Reviewed by** **Date**

**I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me.** I have been given the opportunity to ask to ask any questions I may have regarding this Notice.

**X** _____ **X** _____ **X** _____

**Signature of patient** *(Parent or Guardian if Minor)* **Reviewed by** **Date**

**Dr. Elizabeth Brennan** - 1408 Egypt Road - PO Box 402 - Oaks, PA 19456 - (610) 666-5118

OAKS FAMILY DENTAL

# DENTAL HISTORY:

Date of last dental exam: _____

How many times a day do you brush? _____ How many times a day do you floss? _____

| | Yes | No |
|---|---|---|
| 1. Are your teeth sensitive to: Hot, Cold, Sweets, Pressure? | ☐ | ☐ |
| 2. Do you have any untreated dental problems that you are aware of? | ☐ | ☐ |
| 3. Are you comfortable showing your teeth when you smile? | ☐ | ☐ |
| 4. Do you like the color of your smile? | ☐ | ☐ |
| 5. Are you satisfied with your existing crowns and fillings? | ☐ | ☐ |
| 6. Do you feel your teeth are too long or too short? | ☐ | ☐ |
| 7. Are you interested in replacing any missing teeth? | ☐ | ☐ |
| 8. Are you happy with the alignment of your teeth? | ☐ | ☐ |
| 9. Are your gums receding? | ☐ | ☐ |

10. What's holding you back from your perfect smile? ☐ Fear ☐ Time ☐ Cost ☐ Other_____

| HAVE YOU HAD, OR DO YOU CURRENTLY HAVE: | YES | NO |
|---|---|---|
| 1. Orthodontic treatment | | |
| 2. Oral surgery | | |
| 3. Periodontal treatment | | |
| 4. Your bite adjusted | | |
| 5. Worn and bite plate/night guard | | |
| 6. Removable dental appliances/dentures | | |

| HAVE YOU EXPERIENCED: | YES | NO |
|---|---|---|
| 1. Clicking of the jaw | | |
| 2. Pain/Tenderness | | |
| 3. Frequent Headaches | | |
| 4. Neck Stiffness | | |
| 5. Difficulty chewing, favor 1 side | | |
| 6. Difficulty in opening/closing your mouth | | |

| HAVE YOU NOTICED: | YES | NO |
|---|---|---|
| 1. Loosening of your teeth | | |
| 2. Food catching between your teeth | | |
| 3. Pain/Swelling of gums | | |
| 4. Sores or growths in your mouth | | |
| 5. Bleeding gums when brushing and flossing | | |
| 6. Sensitivity | | |
| 7. Do you smoke or chew tobacco? | | |
| 8. Bad breath – what have you done to treat it? | | |

**DR. ELIZABETH BRENNAN**
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**Oaks, PA 19456**
**610-666-5118**
**www.oaksfamilydental.com**

# Authorization to release records

I, _____, hereby authorize the release of my dental radiographs or copies of such and request that they be sent to:

Dr.'s Name: _____

Address: _____

City, State, Zip: _____

Patient's Name: _____

Family members:

1. _____
2. _____
3. _____
4. _____

Patient's Signature: _____

SS#: _____-_____-_____

Phone #: _____-_____-_____

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**Patient Name:** _____ **D-O-B:** _____

## CONSENT FOR TREATMENT/X-RAYS

I give consent for myself/my child to receive dental treatment deemed necessary by the providers at Oaks Family Dental Associates. These procedures include, but are not limited to; examinations, oral prophylaxes (cleanings), fluoride treatments, extractions, x-rays, restorative treatment, and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.

The standard of care in our office includes the use of dental radiographs (x-rays). The most common types of x-rays we will take are Full mouth X-Ray and Bitewings, those x-rays are helpful in screening both upper and lower jaws and help diagnose the following:

Missing teeth, orthodontic considerations, periodontal conditions (gum and bone disease), defects and malignancies of the bones and jaw, evaluation of wisdom teeth, evaluation of health of tooth, roots, crowns, bridges and implants, abscesses (infections) within the bone associated with teeth or otherwise.

These x-rays are usually part of your normal dental hygiene/examination appointments and are necessary to provide the level of diagnosis and care we strive for. At the time of your appointment our staff will notify you if you are due to have x-rays taken. If you have questions or concerns, please feel free to ask any of our staff members. We value you as a patient and take pride in providing you with optimum dental care.

**Signatures:**

Patient/Parent/Guardian _____ Relationship _____

Witness _____ Date _____

## HIPAA OMNIBUS RULE

# PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____ Patient Name: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

❑ First Name Only ❑ Proper Surname ❑ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- ☐ Cell Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ Home Phone Confirmation
- ☐ Email Confirmation
- ☐ Work Phone Confirmation
- ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- ☐ Cell Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ Home Phone Confirmation
- ☐ Email Confirmation
- ☐ Work Phone Confirmation
- ☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

- ☐ Phone Message
- ☐ Text Message
- ☐ Email
- ☐ **Any of the Above**
- ☐ **None of the Above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____

Please ***print*** name of Patient Please ***sign*** Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

**OFFICE USE ONLY**

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- ☐ It was emergency treatment
- ☐ I could not communicate with the patient
- ☐ The patient refused to sign
- ☐ The patient was unable to sign because
- ☐ Other (please describe) _____

**Signature of Privacy Officer** _____