Vanderbrook
FAMILY DENTISTRY

Getting to Know You As Our Patient

*Date:*_____

Patient Name	Home Address	City, State, ZIP
Home Phone	Social Security No.	Birthday
Cell Phone	Drivers License No.	Sex *(circle one)* Male Female
Work Phone	Marital Status *(circle one)* Single Married Divorced Separated Widowed	Email

Employer	Primary Insurance Company	
Subscriber	ID No.	Group

Responsible Party and/or Insurance Subscriber Information (if different from above)

Patient Name	Home Address	City, State, ZIP
Home Phone	Social Security No.	Birthday
Cell Phone	Drivers License No.	Sex *(circle one)* Male Female
Work Phone	Marital Status *(circle one)* Single Married Divorced Separated Widowed	Relationship to Patient
Employer	Business Address	Occupation

Who may we thank for referring you? _____

Consent and Communication

By providing my phone number and/or email address I am consenting to communication by the dental office through these methods.

Financial Policy

- Payment in full at time of visit is due unless prior financial arrangements have been made.
- Payment may be made by cash, check, or charge.
- A fee will be charged for appointments cancelled without 24 hour notice.

All major treatments will require an appropriate down payment. To avoid misunderstandings, our office manager will be happy to discuss any questions and/or financial concepts regarding fees and payments.
Should it become necessary to retain a collection agency or attorney to collect an outstanding balance on your account, you are responsible and liable for the attorney fees and costs incurred to collect the outstanding balance.

Insurance Policy

If you have dental insurance, we will be happy to help you determine the coverage you have available. Your insurance policy, however, is a contract between you and your insurance company. We, therefore, cannot guarantee payment of your claims or accept the responsibility of negotiating claims with insurance companies or other persons. If your insurance company pays only a portion of the bill or rejects your claim, you are responsible for full payment for services rendered.

_____

Signature Patient/Parental Guardian Date

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Dental History

Why have you come in to see us today? (ex: pain, checkup, etc.) _____

Previous Dentist _____ Last Visit _____ Date of last cleaning _____

Reasons for changing dentists:_____

Have you had an unfavorable experience? _____

Are you nervous about seeing a dentist? ☐ Yes ☐ No If yes, please tell us why:_____

How often do you brush:_____ Do you floss?_____ How often?_____

What is the most important thing about your future smile and dental health? _____

Y N	I clench or grind my teeth during the day or night	Y N	My gums feel tender or swollen	Y N	I like my smile
Y N	My gums bleed while brushing or flossing	Y N	I want my teeth straighter	Y N	I have problems eating
Y N	I avoid brushing part of my mouth due to pain	Y N	I have had a facial or jaw injury	Y N	I want my teeth whiter

Medical History

I consider my health to be (please check one) ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have or have you had any of the following? Please circle Y for yes and N for no

Y N	Heart Disease	Y N	I smoke or use tobacco.	Y N	Kidney Disease
Y N	Heart Murmur/Mitral Prolapse		If yes, how much per day? _____	Y N	History of Drug or Alcohol Addiction
Y N	Stroke		How many years _____	Y N	HIV/AIDS
Y N	High Blood Pressure	Y N	I have consumed alcohol within the last 24 hours	Y N	Immune Suppressed Disorder
Y N	Rheumatic Fever	Y N	I usually take an antibiotic prior to dental treatment	Y N	Hearing Loss
Y N	Anemia	Y N	Liver Disease/ Jaundice	Y N	Fainting Spells
Y N	Blood Disorders	Y N	Hepatitis Type____	Y N	Glaucoma
Y N	Tuberculosis or Lung Disease	Y N	Thyroid Disease	Y N	History of Emotional or Nervous Disorders
Y N	Asthma/Hay Fever	Y N	Diabetes	Y N	Other:_____
Y N	Sinus Trouble	Y N	Arthritis	*For Women Only*	
Y N	Epilepsy/Seizures	Y N	Sexually Transmitted/Venereal Disease	Y N	Are you taking Birth control medication?
Y N	GI issues	Y N	Tumor or Malignancy	Y N	Are/could you be pregnant or nursing?
Y N	Implants/ Artificial Joints	Y N	Cancer/Chemotherapy		
	Hip Knee Other	Y N	Radiation treatment		
Y N	I have had major surgery:	Year:_____ Type of operation?_____			
Y N	Are you under a physicians care?	Date of last medical checkup:_____			

Physician Name and Number:

_____

Pharmacy Name and Number:

_____

Are you allergic to any of the following?

Y N	Aspirin	Y N	Latex, Metals, Plastics
Y N	Ibuprofen	Y N	Anesthetics
Y N	Sulfa Drugs/Sulfites	Y N	Local Anesthetics (Novocaine)
Y N	Penicillin	Y N	Other Medications
Y N	Codeine		_____

Please list all medications you are currently taking:
(If you have a list we are happy to make a copy)

_____

_____

_____

_____

_____

I have answered all health questions to the best of my knowledge. After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures the judgement of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

_____

Signature Patient/Parental Guardian Date

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Consent for Use and Disclosure of Personal Health Information

Patient's Consent

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone:_____ E-mail:_____

Social Security #: _____

I, _____, have received a copy of Dr. Drew Vanderbrook's Notice of Privacy Policies. This form authorizes us to use and disclose your protected health information (PHI) of the purposes of healthcare operations, treatment and payment activities.

Before signing , please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your PHI.

For questions concerning our Notice of Privacy Polices, please contact our office manager. You may reach them at 214-821-5200.

Initial by which option you choose:

_____ *I have read the Notice of Privacy Policies and I consent to your use of my PHI for the purposes of healthcare operations, treatment an payment activities.*

_____ *I revoke the above consent for the use and disclose of my PHI. However, by doing so, I understand that the office reserves the right to discontinue treatment. This revocation also does not negate any prior actions while acting under consent.*

Signature (Patient, Parent, or Guardian):

_____

Office Use Only

On _____, an Acknowledgement of Receipt of Notice of Privacy Policies form was delivered. The form was not signed due to :

☐ Communication barriers which prevent acknowledgement ☐ A refusal to sign

☐ An emergency which prevents acknowledgment ☐ Other