Clark F. Brown, Jr. DDS, PA
2113 Sarno Road, Melbourne, FL 32935

GENERAL INFORMATON

Date: / / E-mail : _____

First Name: _____ M.I.: _____ Last Name: _____

Street Address: _____ Apt: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Cell Phone: _____ Fax: _____

Driver's License: _____ Date of Birth: / / SSN: _____

Marital Status: _____

Spouse Name: _____

Spouse Phone: _____ Spouse's Date of Birth: / /

In Case of Emergency Contact

Name: _____ Home Phone: _____

Relationship: _____ Work Phone: _____

How did you hear about us? _____

EMPLOYMENT

Occupation: _____ How long? _____

Employer: _____ May we call you at work? Yes No

Employer Address: _____

City: _____ State: _____ ZIP: _____

Patient Name:_____

Date of Birth ____/____/_____

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MEDICAL HISTORY

Office Use
ASA

Have you ever had any of the following? (Circle yes or no)

Heart Attack or Disease Yes No
What type & when _____
_____

High Blood Pressure Yes No
Pacemaker Yes No
Mitral Valve Prolapse Yes No
Abnormal Bleeding Yes No
Anemia Yes No
Blood Thinners Yes No
What type? _____
Stroke Yes No
When? _____
Epilepsy or Seizures Yes No
Last seizure: _____
Joint Replacement Yes No
When? _____
Asthma or Emphysema Yes No
Use an inhaler? _____
Sinus Problems Yes No
Tobacco Use Yes No
How much? _____
Tuberculosis (TB) Yes No
Cold Sores / Fever Blisters Yes No

Please list any other medical conditions and surgeries you have or have had:

_____

_____

ALLERGIES:

Penicillin Yes No
Erythromycin Yes No
Tetracycline Yes No
Sulfa or Sulfides Yes No
Aspirin Yes No
Codeine Yes No
Latex Yes No
List other allergies: _____

_____

Cancer / Chemotherapy Yes No
Type & when? _____
_____

Radiation Therapy Yes No
Type & when? _____
HIV / AIDS Yes No
Liver Disease / Hepatitis Yes No
Type & when? _____
Diabetes Yes No
If yes, A1C:_____
Kidney Disease Yes No
Thyroid Problems Yes No
Steroid Use in past year Yes No
When & how long? _____
Bisphosphonates Yes No
(Fosamax, Boniva, Reclast, etc.)
If yes, IV_____ Oral Only _____
When taken? _____
Complications with anesthesia Yes No
Describe _____
_____

Please list all medications you are taking (including non-prescription):

Medication	**Reason**

Additional sheet attached Yes No

I certify that the information I have given on this medical history form is correct and complete to the best of my knowledge. I also understand that complete, correct and up-to-date information is important for my well-being and safety. I understand and agree that it is my responsibility to inform this office of any changes in my medical status before any treatment is rendered.

Patient Signature: _____ Date: ____/____/_____

Patient Name: _____

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MEDICATION UPDATE

If there have been changes in the medications that you take, please complete the box by listing **ALL prescription medications, herbal products and over-the-counter products you are taking.**

If you take any "street drugs", please list them. *Any* drug can interact with the medications we administer. Your medical information is private and your health is important.

I certify that the information I have given on this medication update form is correct and complete to the best of my knowledge. I also understand that complete, correct and up-to-date information is important for my well-being and safety. I understand and agree that it is my responsibility to inform this office of any changes in my medical status before any treatment is rendered.

There have been NO other changes to my medical condition.

☞ Patient Signature_____ Date ____/_____/_____

Patient Name: _____

Date: / /

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MEDICAL INFORMATION

Medical Doctor Information

Family Physician's Name: _____

Family Physician's Address: _____

City: _____ State: _____ ZIP: _____

Family Physician's Phone: _____ Date of your last visit: _____

Are you under the regular care of a specialist? _____

Specialist #1

What specialty? _____

What are you being treated for? _____

Specialist's Name: _____

Specialist's Address: _____

City: _____ State _____ ZIP: _____

Specialist's Phone: _____ Date of your last visit: _____

Specialist #2

What specialty? _____

What are you being treated for? _____

Specialist's Name: _____

Specialist's Address: _____

City: _____ State _____ ZIP: _____

Specialist's Phone: _____ Date of your last visit: _____

Please list below any other medical professionals whose care you are currently under:

Patient Name: _____

Date: / /

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DENTAL HISTORY

Previous or Current Dentist

Do you want us to be your primary dentist? Yes No

If not, will you maintain regular check-ups and cleanings with your current dentist? Yes No

Previous or Current Dentist's Name: _____

Dentist's Address: _____

City: _____ State: _____ ZIP: _____

Dentist's Phone: _____ Date of your last visit: / /

DENTAL CONCERNS

Are you currently in pain? Yes No If yes, describe: _____

What dental treatment(s) are you seeking? _____

DENTAL HISTORY

Do your gums bleed?	Yes	No	How many times a day do you brush?		
Are your teeth sensitive?	Yes	No	What type of tooth brush do you use?		
Do you wear dentures?	Yes	No	How often do you floss?		
Do you have TMJ problems?	Yes	No	Are you happy with your smile?	Yes	No
Have you had braces?	Yes	No	Do you want to avoid losing your teeth?	Yes	No
Have you had root canals?	Yes	No	Have you been treated for gum disease?	Yes	No

Describe any bad dental experiences you have had. _____

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STATEMENT OF UNDERSTANDING & CONSENT FOR TREATMENT

I certify that the information I have given herein is correct and complete to the best of my knowledge. I agree that if there are any changes to my medical condition, I will inform the dental staff BEFORE any dental treatment is performed. I agree that if any adverse conditions occur as a result of my failure to provide accurate medical conditions and/or updates, I will not hold Dr. Brown or his staff responsible.

I agree to any examinations and x-ray radiographs Dr. Brown deterimes necessary for the diagnosis of my dental condition(s). I agree to have any local anesthetics (dental numbing injections) administered as required for my treatment, unless I have an allergy to them. I will be informed by the dental staff of any proposed treatment procedures and will be afforded the opportunity to ask questions before they are performed. Once I agree to treatment, I agree that Dr. Brown may use any dental materials, laboratories or techniques he deems appropriate for my treatment.

☞ Patient Signature _____ Date _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION (HIPAA)

SECTION A:

First Name: _____ M.I.: _____ Last Name: _____

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 health care operations. **WE WILL NOT RELEASE ANY OF YOUR HEALTH INFORMATION TO MARKETORS OR SOLICITORS.**

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign the Consent. Our Notice provides a description of out treatment, payment activities, and health care 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 is available from the Contact Person. 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.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting our office manager at 321-259-9429 or at the office located at 2113 Sarno Road, Melbourne, Florida.

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 of the Onsent before we receive your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

I, _____ (or my personal representative), have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations. I also agree that my protected health information may also be disclosed to the following person(s):_____

Signature _____ **Date** _____

☞ If this consent is signed by a personal representative on behalf of the patient, complete the followiing:

Personal Representative's Name _____ Relationship to Patient _____

Patient Name: _____

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INSURANCE INFORMATION

Primary Dental Insurance

Insurance Company Name: _____

Insured's Name: _____ Relation to Patient: _____

Group Number: _____ Insured's Policy ID Number: _____

Insured's Date of Birth: _____ Insurance Company Phone: _____

Insured's Employer: _____ Insured's Work Phone _____

Secondary Dental Insurance

Insurance Company Name: _____

Insured's Name: _____ Relation to Patient: _____

Group Number: _____ Insured's Policy ID Number: _____

Insured's Date of Birth: _____ Insurance Company Phone: _____

Insured's Employer: _____ Insured's Work Phone _____

OFFICE INSURANCE POLICY AND ASSIGNMENT OF BENEFITS - PLEASE READ CAREFULLY

I understand that an insurance policy is not a guarantee of payment. While every effort will be made to insure the accuracy of my insurance plan benefits, I understand that the office estimate of my insurance benefits is NOT a guarantee of accuracy and in fact will **not be exact**. I understand that a pre-determination of benefits will result in the most accurate estimate of my insurance plan benefits, however even a pre-determination of benefits is NOT a guarantee of payment by the insurance company.

I understand that the office will file for a pre-determination of benefits only on estimated claims exceeding $500.00 and that a pre-determination of benefits may take in excess of six weeks to be processed by my insurance company. I understand that the filing of my insurance claim is a courtesy extended by the office and that the office is not an agent for my insurance company, and has no control or influence over them, their policies or their payments.

I understand that my insurance company has not examined me and does not know my dental condition and dental needs. I understand that my insurance company may deny payment or change the treatment to a lesser cost treatment option and that this is done strictly for the economic benefit of my insurance company and not to my personal benefit. I understand that my insurance company may not pay for certain materials or procedures and that this is done for the economic benefit of my insurance company and not for my benefit. I understand that Dr. Brown will recommend and use materials and treatment procedures that are in my best interest and not based upon my insurance company's payment considerations.

I agree to be responsible for the full amount of the charges for my treatment. If I elect to have payment (if any) made to Dr. Brown by my insurance company, this will be applied towards the full amount of charges for my treatment.

I hereby authorize the release of any information pertaining to my treatment and claim to the above insurance companies and their representatives. I authorize the release of my information to the above insurance companies by electronic submission through national clearing houses that are governed by the HIPPA privacy act.

I hereby authorize payment to be made directly to Dr. Clark Brown of the group insurance benefits otherwise payable to me.

☞ Insured Signature _____ Date _____

Patient Name: _____

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FINANCIAL POLICY & AGREEMENT

Thank you for allowing us to be your dental care provider. We are committed to providing the highest quality of dental care to all of our patients. The prompt payment of your treatment fees allows us to continue providing the highest quality of care. In the pursuit of these goals, we have established the following financial policy:

ESTIMATES We will give you a cost estimate before treatment is rendered. We will try to insure that the cost estimate is complete and accurate, however there are circumstances when it becomes impossible to know exactly what treatment needs to be performed. Sometimes the dental condition requires less treatment, in which case your treatment fees will be less than estimated. Other times, the dental condition requires more treatment than initially anticipated, in which case your treatment fees will be more than estimated. If more treatment is required than initially estimated, you will be informed of the treatment required and fees before the additional treatment is performed.

PAYMENT DUE Full payment of the fees are due at the time of service. We accept cash, check (drawn on a local bank), VISA, Mastercard and Discover. Treatment which requires more than two hours of appointment time will require payment in full five business days prior to the appointment. Appointments will automatically be cancelled if payment is not received.

PAYMENT PLANS Payment plans are available only through CareCredit. Interest free plans are available to qualified individuals. CareCredit and NOT this office determines who may qualify and the amount of credit available.

BROKEN APPOINTMENTS We require 24 hours notice to cancel or reschedule an appointment. There will be a per-hour fee assessed for failure to provide 24 hours notice to cancel or reschedule an appointment.

AFTER-HOUR EMERGENCY CARE We provide after-hours emergency care for established patients only. There will be a fee charged for after-hours care.

INSURANCE If we do not participate in your dental insurance plan, you still may receive benefits payable by your dental insurance company. You will be required to pay for treatment in full. We will file your insurance claim for you, assigning benefits directly to you. Your insurance company will reimburse you according to their own fee schedules and restrictions. We regularly monitor the usual and customary fees for our area and insure that we are within this range. The insurance company's "usual and customary fees" are NOT based upon the current fees being charged in a particular area.

If we are a participating provider for your dental insurance, we will file your insurance claim for you. We will estimate your insurance benefit and you will be required to pay the estimated balance at the time of treatment. Since the insurance benefit is an estimate only, you will be required to pay any amount still due after your insurance company pays on the claim. If there is a credit on your account after the insurance payment, this amount will be refunded to you or remain as a credit on your account for future treatment, as your choice. The **OFFICE INSURANCE POLICY AND ASSIGNMENT OF BENEFITS** is made a part of this **Financial Policy & Agreement**.

COLLECTION OF PAST DUE ACCOUNTS Accounts that are not paid according to this **Financial Policy & Agreement** may be turned over to an independant collection agency. In the event that your account is turned over for collection, you will be responsible for all fees incurred in the collection of your account.

RETURNED CHECKS Any checks returned due to insufficient funds must be paid within five business days and will incur a $25 returned check fee. Returned checks not paid in full (including the returned check fee) within five days will incur a 1.5% per month interest charge and the account may be turned over for collection. Any checks returned for being written on a closed account will be forwarded to the State Attorney and the account immediately sent to collection.

I, _____ have read, understand, and agree to abide by this **Financial Policy & Agreement.**

(Print Name of Responsible Party)

☞ Responsible Party Signature _____ Date _____

Relationship to Patient _____