Autumn Hill
DENTAL

Welcome To Our Practice

Please fill out both sides of this form so we can provide you with the safest optimum care. All information will be kept confidential. The doctor and staff will review it with you and answer any questions you may need help with. Thank you.

CONTACT INFORMATION

Name: _____ Birthdate (d/m/y): _____

Home Address: _____ Home: _____

_____ Cell: _____

Occupation: _____ Work: _____

Email: _____ Title: Mr Mrs Ms Dr

EMERGENCY / DOCTOR INFO

Person To Notify: _____ Person Phone: _____

Relationship: _____ Person Cell: _____

Family Doctor: _____ Doctor Phone: _____

Doctor Address: _____

MEDICAL INFORMATION

Are you being treated for any medical conditions? q Yes q No Date of last medical exam: _____

Has your general health changed in the last year? q Yes q No Do you smoke? Amount: _____

If YES to either question above, please explain: _____

List all medications taken: _____

List all of your allergies: q Penicillin q Sulpha q Aspirin q Anesthetic q Latex q Codeine

q Other: _____

Are you breastfeeding or pregnant? q Yes q No

Any diseases that run in your family? _____

List hospitalization dates and reasons: _____

PLEASE CHECK ALL THAT APPLY

q Alcohol/Drug Use
q Anemia
q Angina/Chest Pains
q Arthritis
q Artificial Joint
q Asthma
q Auto-immune Disease
q Blood Disorder
q Cancer
q Chemotherapy
q Diabetes
q Dizziness/Vertigo
q Emphysema
q Epilepsy/Seizures
q Easy Bleeding/Bruise
q Fainting
q Glaucoma
q Head Injury
q Heart Attack
q Heart Disease
q Heart Murmur
q Heart Surgery
q Hemophilia
q Hepatitis
q High Blood Pressure
q HIV (AIDS)
q Immunosuppression
q Jaundice
q Kidney Disease
q Liver Disease
q Low Blood Pressure
q Lung Disease
q Lupus
q Mental Disorders
q Mitral Valve Prolapse
q Multiple Sclerosis
q Nervous Disorders
q Osteoporosis
q Pacemaker
q Poor Healing
q Radiation Treatment
q Rheumatic Fever
q Sinus Problems
q Shortness of Breath
q Steroid Therapy
q Stomach Problems
q Stroke
q Thyroid Disease
q TMJ Disorder
q Tuberculosis
q Tumors
q Ulcers

Do you have any disease, problem or condition not listed above? _____

DENTAL CONCERNS

I am concerned about:

q Tooth pain	q Esthetics	q Crooked/shifting teeth	q Tooth color/shape
q Bleeding gums	q Loose Teeth	q Chewing power/ability	q Denture fit
q Bad breath	q Nervousness	q Sensitive teeth	q Missing teeth

Other concerns: _____

_____

_____

INSURANCE INFORMATION

Insurance Company: _____ Group/Plan #: _____

Subscriber Name: _____ Birthdate: _____

Relationship to Patient: q Self q Spouse q Dependent Certificate #: _____

Secondary Insurance: _____

_____

_____

PRIVACY POLICY

Our office complies with privacy protection guidelines and requires patients to provide consent for us to collect, use, disclose or update any personal information. Staff members are trained to protect the privacy of your personal information, and Dr. Braun is the Privacy Information Officer with whom you may discuss these policies.

By signing below, you consent to the collection of personal and health information about you, or your children (if they are minors and patients of our office) for use in the routine operation of our office, such as for the purposes of examining your health, providing treatment, managing appointments, and other related matters. Information may be collected using paper forms, telephone, email, chair-side discussions and interviews, photographs and x-rays.

You also consent to your information being disclosed: to insurers, payment organization and 3rd parties that may be involved in payment/pre-approval of treatment estimates; to any heath care practitioner involved in your health (e.g. physicians, dentists, etc.); to any potential purchaser and his advisors of this dental office; and for teaching and demonstrating purposes (e.g. lectures, practice web-site, brochures, advertisements) on an anonymous basis.

You are aware that you can withdraw your consent at any time, given reasonable notice in writing. If you should withdraw your consent, you understand that Dr. Braun may be unable to provide you with proper dental care.

To the best of my knowledge, the above information is complete and correct. I promise to inform the office immediately of any changes in my medical status. I consent to examination and treatment as advised by Dr. Braun. I agree with the privacy policy as stated above. I understand that payment is due at the time when services are rendered (by credit card, debit or cash) and that any alternate payment arrangements must be made in advance of treatment.

Patient/Parent/Guardian Signature: _____ Doctor: _____

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