JEFFREY BROWN, DMD
personalized dental care.

REGISTRATION FORM
Welcome! Please print, sign & return to check-in.

PATIENT INFORMATION

Patient's Name:		❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid		
Are you the patient? ❑ Yes ❑ No	If not, what is your name?	Relationship to Patient	Patient Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Social Security no.:		Best # to reach you: ( )		
City:	State/Zip Code:	Email Address:				
Occupation/Student:	Employer:	Work Phone #: ( )				
Referred to us by (please check one box):	❑ Family	❑ Friend	❑ Insurance Directory	❑ Insurance Website		
❑ Employee	❑ Co-Worker	❑ Close to home/work	❑ Internet	❑ Other		
Name of person who referred you:						

FINANCIAL RESPONSIBILITY / INSURANCE INFORMATION

(Please give your insurance card/cards and driver's license to the receptionist.)

Person financially liable for charges: (If covered by insurance skip to **A**)	Birth date: / /	Address (if different):	Phone #: ( )		
❑ Parent ❑ Spouse ❑ Other	Is this person you? ❑ Yes ❑ No	Is this person a patient here? ❑ Yes ❑ No			
Social Security #:	Employer:	Employer address:	Employer phone no.: ( )		
A. Is this patient covered by insurance? ❑ Yes ❑ No					
Please indicate primary insurance	❑ Delta Dental	❑ MetLife	❑ Guardian	❑ Aetna	❑ Cigna
❑ Humana Dental	❑ United Concordia	❑ Anthem	❑ Discounted Plan	❑ Other	
Subscriber's name:	SS#:	Birth date: / /	Group #:	ID#:	Effective Date: / /
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:	Social Security #:	Birth date: / /		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship:	Phone #: ( )	Alternate #: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the dentist. I understand that I am financially responsible for any balance. I also authorize the dentist or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

651 Perimeter Drive, Suite 630
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phone: 859.263.5755

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REGISTRATION FORM
personal health information

Patient Name: _____ Date: _____

Are you allergic to?

☐ Latex ☐ Dental Anesthetics ☐ Penicillin ☐ Erythromycin ☐ Aspirin ☐ Codeine ☐ Sulfa ☐ Metals ☐ Other

Do you use tobacco products? ☐ Yes ☐ No ☐ Cigarettes ☐ Pipes ☐ Chew ☐ Dip ☐ Daily ☐ Seldom

Consume alcohol beverages? ☐ Yes ☐ No ☐ Daily ☐ Seldom

WOMEN: Are you or do you think you might be pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

How would you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you had or do you currently have any of the following? List medication(s) or drug(s) taken for the condition.

☐ Yes	☐ No	Heart Disease	Medication _____	Notes _____
☐ Yes	☐ No	Heart Attack	Medication _____	Notes _____
☐ Yes	☐ No	Chest Pains	Medication _____	Notes _____
☐ Yes	☐ No	Stroke	Medication _____	Notes _____
☐ Yes	☐ No	Rheumatic Fever	Medication _____	Notes _____
☐ Yes	☐ No	Mitral Valve Prolapse	Medication _____	Notes _____
☐ Yes	☐ No	Congenital Heart Disease	Medication _____	Notes _____
☐ Yes	☐ No	Artificial Heart Valves	Placed when? _____	Notes _____
☐ Yes	☐ No	Heart Pacemaker	Placed when? _____	Notes _____
☐ Yes	☐ No	High Blood Pressure	Medication _____	Notes _____
☐ Yes	☐ No	Blood Transfusion	When? _____	Notes _____
☐ Yes	☐ No	Epilepsy or Seizures	Medication _____	Notes _____
☐ Yes	☐ No	Drug Addiction/Alcoholism	Medication _____	Notes _____
☐ Yes	☐ No	Implants	Type _____	Notes _____
☐ Yes	☐ No	Kidney Problems	Medication _____	Notes _____
☐ Yes	☐ No	Thyroid Problems	Medication _____	Notes _____
☐ Yes	☐ No	Liver Problems	Medication _____	Notes _____
☐ Yes	☐ No	Mental Health Problems	Medication _____	Notes _____
☐ Yes	☐ No	Bleeding Problems	Medication _____	Notes _____
☐ Yes	☐ No	Genetic Problems	Medication _____	Notes _____
☐ Yes	☐ No	Hormonal Problems	Medication _____	Notes _____
☐ Yes	☐ No	Lung Problems	Medication _____	Notes _____
☐ Yes	☐ No	Venereal Disease	Medication _____	Notes _____
☐ Yes	☐ No	HIV/AIDS	Medication _____	Notes _____
☐ Yes	☐ No	Cortisone/Steroids	Medication _____	Notes _____
☐ Yes	☐ No	Persistent Cough	Medication _____	Notes _____
☐ Yes	☐ No	Artificial Joints	Type _____	When? _____
☐ Yes	☐ No	Asthma	Medication _____	Notes _____
☐ Yes	☐ No	Cancer	Type _____	When? _____
☐ Yes	☐ No	Sinus Trouble	Medication _____	Notes _____
☐ Yes	☐ No	Allergies	Medication _____	Notes _____
☐ Yes	☐ No	Arthritis	Medication _____	Notes _____
☐ Yes	☐ No	Hepatitis	Medication _____	Notes _____
☐ Yes	☐ No	Diabetes (Type: ____)	Medication _____	Notes _____
☐ Yes	☐ No	Tuberculosis	Medication _____	Notes _____

List any medications/vitamins/supplements not listed above: _____

Are you currently under the care of a physician? ☐ Yes ☐ No If yes, for what reason? _____

Name of your physician: _____ Location/Phone# _____

Have you been hospitalized within the past 12 months? ☐ Yes ☐ No If yes, for what reason? _____

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REGISTRATION FORM
personal dental history

Patient Name: _____ Date: _____

Reason for today's visit: _____

Have you had or do you currently have any of the following?

☐ Yes	☐ No	Orthodontic Treatment (Braces)	☐ Yes	☐ No	Taken antibiotic before dental appts
☐ Yes	☐ No	Oral Surgery	☐ Yes	☐ No	Clicking/Popping of Jaw
☐ Yes	☐ No	3rd molars removed (Wisdom Teeth)	☐ Yes	☐ No	Bleeding/Swollen Gums
☐ Yes	☐ No	Deep cleaning	☐ Yes	☐ No	Jaw Pain
☐ Yes	☐ No	Gum Treatment	☐ Yes	☐ No	Floss
☐ Yes	☐ No	Root Canal Therapy	☐ Yes	☐ No	Mouth Rinse
☐ Yes	☐ No	Dentures	☐ Yes	☐ No	Clench/Grind
☐ Yes	☐ No	Partials	☐ Yes	☐ No	Canker Sores
☐ Yes	☐ No	Oral Piercing	☐ Yes	☐ No	Cold Sores
☐ Yes	☐ No	Teeth Whitening	☐ Yes	☐ No	Dental Implants
☐ Yes	☐ No	Night Guard	☐ Yes	☐ No	Loose Teeth
☐ Yes	☐ No	Manual Toothbrush	☐ Yes	☐ No	Sensitivity to Hot
☐ Yes	☐ No	Power Toothbrush	☐ Yes	☐ No	Sensitivity to Cold
☐ Yes	☐ No	Water Pik	☐ Yes	☐ No	Latex Allergy
☐ Yes	☐ No	Veneers	☐ Yes	☐ No	Broken/Dislocated Jaw
☐ Yes	☐ No	Bad Breath	☐ Yes	☐ No	Missing teeth

Name of previous dentist: _____ Date of last visit: _____

Are you happy with the appearance of your teeth? ☐ Yes ☐ No If no, what would you like to change? _____

Have you ever had a bad experience/problem associated with dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

_____

PLEASE READ BELOW AND SIGN

Your signature will indicate that you have read the paragraph and agree to these statements.

The information given above regarding the patient medical and dental histories is accurate and complete to the best of my knowledge. I will not hold the dentist or his staff responsible for any errors or omissions that I may have made in the completion of this form. I understand that if any changes occur, it is my responsibility to inform the dentist and his staff.

_____ _____

Patient/Guardian Signature Date

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REGISTRATION FORM
financial policy agreement

We are dedicated to providing the best possible patient care, and we want you to completely understand our financial policies. If you have any questions about this information, or are uncertain regarding insurance information, do not hesitate to ask us. **WE ARE HERE TO HELP YOU**.

PATIENTS WITH INSURANCE

If you have insurance, please ask us if we are in-network with your plan. If we are not in-network, we still accept most insurance plans and will gladly file your claim. Deductibles and co-pays are expected at the time of service. We can only estimate the amount you owe, which is based on the information your insurance carrier provides us. If your insurance carrier pays less than their estimated portion, you will be responsible for the remaining balance upon receiving your bill. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select services they will not cover.

TREATMENT PLANS

Treatment plans are based upon an estimated calculation. It may be necessary to do additional treatments, which will result in a change of fees and the amount you owe.

COMPOSITE RESTORATIONS

We provide composite (tooth colored) restorations. Your insurance carrier may only pay for amalgam (silver/mercury) restorations, therefore you are responsible for the amount not covered by your insurance carrier and this amount is due at the time of service.

PAYMENT PLAN OPTION

We may be able to offer extended, interest-free financing for larger treatment plans through 3rd party payors.

ASSIGNMENT AND RELEASE OF INFORMATION

I assign the benefits from my insurance carrier to Jeffrey Brown, DMD for the dental benefits I am entitled for any services furnished to me. I authorize Jeffrey Brown, DMD to release to my insurance carrier any information needed to determine benefits for my care.

AUTHORIZATION

I, the undersigned, have read and agree to be bound by the financial policy's terms stated in the paragraphs above and accept full financial responsibility for the fees charged. I also understand and agree that such terms may be amended from time-to-time.

Patient Signature	Date	Witness	Date
Print Patient Name		Parent/Legal Guardian	Date

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REGISTRATION FORM
informed consent

You the patient have the right to accept or reject dental treatment recommended by Dr. Brown. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with Dr. Brown and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide Dr. Brown with accurate information before, during and after treatment. It is equally important that you follow Dr. Brown's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by Dr. Brown.

If you are a woman on oral birth control medication you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if Dr. Brown prescribes, or if you are taking antibiotics.

As with all surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly known risks and complications of treatment include, but are not limited to the following:

1. Pain, swelling, and discomfort after treatment.
2. Infection in need of medication, follow-up procedure or other treatment.
3. Temporary, or on rare occasion, permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums, and tongue along with possible loss of taste.
4. Damage to adjacent teeth, restorations or gums.
5. Possible deterioration of your condition which may result in tooth loss.
6. The need for replacement of restorations, implants or other appliances in the future.
7. An altered bite in need of adjustment.
8. Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist.
9. Root tip, bone fragment or a piece of dental instrument may be left in your body, and may have to be removed at a later time if symptoms develop.
10. Jaw fracture.
11. If upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment.
12. Allergic reaction to anesthetic or medication
13. Need for follow-up treatment, including surgery.

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of recommended treatment with Dr. Brown. Be certain all of your concerns have been addressed to your satisfaction by Dr. Brown before commencing treatment.

Patient Signature	Date	Witness	Date
Print Patient Name		Parent/Legal Guardian	Date

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