Evelyn M. Brown, D.D.S. 455 Swiftside Drive Suite 101 Cary, NC 27518 (919-851-5166)

Welcome to our practice, and thank you for completing this form to update your records in our office.

PATIENT INFORMATION

Name: _____
Last First Middle Initial Preferred Name

Address: _____
Street City State Zip

( ) Home # _____ ( )Work #_____ ( ) Cell # _____

( ) Email: _____ *(Please Check Preferred contact method)*

Whom may we thank for referring you? _____

Birth date: _____ SS #_____ Married__ Single__ Other__ Child__ Sex: Male__ Female__

Name of person responsible for account: _____ Relation to patient: _____

Please list address and phone numbers if different from yours: _____

Person to Contact in case of Emergency: _____ Phone: _____

DENTAL HISTORY

Previous Dentist: _____ Date of last dental x-rays _____

Please mark with an " x " any of the following which you currently have or have had:

Do your gums bleed when you brush or floss? _____
Are your teeth sensitive to Cold? ____ Hot? _____ Sweets?_____ Pressure?_____
Is your mouth dry? _____
Have you had Periodontal (gum) treatment?____ Orthodontic (braces) treatment?_____ Endodontic (root canal) treatment?____
Have you had any problems associated with previous dental treatment? ____ Anesthesia? ____ If yes, please explain:
_____
Is your home water supply fluoridated? _____
Do you have any clicking, popping, or discomfort in your jaw? _____ Do you grind your teeth? _____
Do you have sores or ulcers in your mouth? _____ Do you wear dentures or partials? _____
Have you ever had a serious injury to your head or mouth? _____

MEDICAL HISTORY

Physician's name: _____ Phone number:_____
Have you had any serious illnesses or operations? _____
If yes, please describe:_____
Are you currently under any physician's care for any specific condition? _____
If yes, please describe: _____
Have you had your tonsils removed? _____
Females: Are you pregnant? _____ Nursing? _____
Children: Weight: _____

Please mark with an "x" any of the following illnesses or conditions which you currently have or have had:

___Abnormal bleeding
___Acid reflux
___ADD (Attention Deficit Disorder)
___Allergies
Specify: _____
___Anemia
___Angina
___Arthritis
___Artificial Heart Valve
___Autoimmune disease
___Back problems
___Cancer
___Cortisone Treatment
___Persistent Cough
___Diabetes
___Emphysema
___Epilepsy
___Fainting spells/seizures
___Glaucoma
___Headaches
___Heart attack
___Heart murmur
___Other heart condition
Specify _____
___Hemophilia
___Hepatitis A__ B__ C__
___High blood pressure
___Low blood pressure
___HIV or AIDS
___Jaw pain
___Joint replacement
___Kidney disease
___Latex sensitivity
___Liver disease
___Mitral valve prolapse
___Neurological disorder
___Nickel sensitivity
___Osteoporosis
___Pacemaker
___Radiation treatment
___Recurring infection
___Respiratory disease
___Rheumatic fever
___Scarlet fever
___Shortness of breath
___Sinus trouble
___Sleep disorders
___Stroke
___Swelling of feet/ankles
___Thyroid problems
___Tobacco use
Type_____
___Tuberculosis
___Ulcer

Have you ever taken, are you currently taking, or scheduled to begin taking Fosamax or Actonel? _____
Are you currently taking any medications (prescription or over-the-counter)? Please list: _____
_____
___
Do you have any drug allergies? _____ If yes, please list: _____
Have you had an adverse reaction to dental or medical treatment or anesthesia? _____ **If yes, please discuss with clinical staff.**
Do you have any disease, condition or problem not listed above that we should know about? _____

As a courtesy to our patients, we will file for your dental insurance benefit.

Your estimated co-pay is due at time of service.

PRIMARY DENTAL INSURANCE

Name of insurance company: _____ Group #:_____

Insurance Company address:_____

Person who is the primary insured under this policy:_____ Their relationship to you:_____

That person's birth date: _____ That person's SS #:_____

If through an employer, name of employer: _____

If this is a private policy, is it through an organization?_____ If yes, name of organization:_____

SECONDARY DENTAL INSURANCE

Name of insurance company: _____ Group #:_____

Insurance Company address:_____

Person who is the primary insured under this policy:_____ Their relationship to you:_____

That person's birth date: _____ That person's SS #:_____

If through an employer, name of employer: _____

If this is a private policy, is it through an organization? _____ If yes, name of organization:_____

AUTHORIZATION AND RELEASE / FINANCIAL AGREEMENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child or other dependent, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with the company listed above and assign directly to Evelyn M. Brown, D.D.S., P.A. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my healthcare information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian or Personal Representative _____ Date _____

Please print name _____

Authorization for Release of Information – Compound Release

Name of Patient Date of Birth

is authorized to release protected health information about the above-named patient in the following manner and/or to selected persons.

Check each person/entity approved to receive information.	Check type of information that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other_____
☐ Other person (s) (provide name and phone number)	☐ Financial ☐ Medical
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff (Example: pre/post procedure) ☐ Other	☐ May be posted in office ☐ May be posted on website ☐ Other_____

Patient Rights:

I have the right to revoke this authorization at any time by contacting our office.

e disclosed as described in this document.

as already been disclosed but will be effective going forward. Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipie

my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

Date _____

_____
Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

Revised Jan 2018

Evelyn M. Brown, D.D.S., P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____Individual refused to sign
____Communications barriers prohibited obtaining the acknowledgement
____An emergency situation prevented us from obtaining acknowledgement
____Other (Please specify)