PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2 Section 3

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

EMERGENCY CONTACT:: _____

EMERGENCY #:: _____

Credit Card # : _____

Expiration Date: _____

CareCredit Acct.# : _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

MEDICAL HISTORY

Patient Name _____

Sex_____ Height _____ Weight_____ DOB/Age _____

	Yes	No
1. Do You have current health **problems?**		
2. Are you now under a physician's care? If yes, for what condition?_____		
3. Name and Phone Number of your Physician _____		
4. What Medications are you currently taking?		
5. Have you ever taken **Fen-Phen-Redux?**	Yes	No
6. Have you ever taken **Bisphosphonates** such as Fosamax ,Boniva, Actonel, Prolia and Xgeva?	Yes	No
7. Have you been hospitalized or had serious illness within the past 5 years? If yes, reason_____	Yes	No

ALLERGIES

NOTES:

Local Anesthetics	Yes	No
Antibiotics	Yes	No
Latex (Balloons, gloves, bandaids, etc.)	Yes	No
Aspirin	Yes	No
Iodine	Yes	No
Codeine or other narcotics	Yes	No
Other Allergies	Yes	No

Check YES or NO if you have or have had the following:

AIDS/HIV positive	Yes	No
Anaphylaxis	Yes	No
Anemia	Yes	No
Arthritis (Rheumatism)	Yes	No
Artificial Heart Valves	Yes	No
Artificial Joints	Yes	No
Asthma	Yes	No
Atopic (Allergy Prone)	Yes	No
Back Problems	Yes	No
Blood Disease	Yes	No
Cancer	Yes	No
Chemical Dependency	Yes	No
Chemotherapy	Yes	No
Circulatory Problems	Yes	No
Cortisone Treatments	Yes	No
Cough (Persistent)	Yes	No
Cough Up Blood	Yes	No
Diabetes	Yes	No
Epilepsy	Yes	No
Fainting	Yes	No
Food Allergies	Yes	No
Glaucoma	Yes	No
Heart Murmur	Yes	No
Heart Problems (describe)	Yes	No
Hemophilia	Yes	No
Herpes	Yes	No
Hepatitis	Yes	No
High Blood Pressure	Yes	No
Jaw Pain	Yes	No
Kidney Disease	Yes	No
Liver Disease	Yes	No
Mitral Valve Prolapse	Yes	No
Nervous Problems	Yes	No
Pacemaker/Heart Surgery	Yes	No
Psychiatric Care	Yes	No
Rapid Weight Gain/Loss	Yes	No
Radiation Treatment	Yes	No
Rheumatic/Scarlet Fever	Yes	No
Shingles	Yes	No
Shortness of Breath	Yes	No
Skin Rash	Yes	No
Spina Bifida	Yes	No
Stroke	Yes	No
Surgical Implant	Yes	No
Swelling of Feet or Ankles	Yes	No
Thyroid Disease or Problems	Yes	No
Tobacco Habit	Yes	No
Tonsillitis	Yes	No
Tuberculosis	Yes	No
Ulcer/Colitis	Yes	No
Venereal Disease	Yes	No

Patient Sig._____Date_____Doctor Sig._____

Patient Preferences

Patient: _____ **Date:** _____

Briefly tell us how you feel about your teeth, your smile, and your dental expectations.

1. What are your expectations from this office? _____
   _____
   _____

2. Would you like to learn how you can have all of your teeth for the rest of your life? ❑ yes ❑ no

3. If you are already missing some teeth, would you like to learn how you can avoid having full dentures? ❑ yes ❑ no

4. Do you like your smile? ❑ yes ❑ no

5. If the answer is NO, what don't you like and what changes would you like to see? _____
   _____
   _____

6. If you feel that your teeth have yellowed, or are not white enough, would you like to learn about tooth whitening? ❑ yes ❑ no

7. Are you interested in an overall cosmetic dental evaluation? ❑ yes ❑ no

8. If you are contemplating a dental cosmetic change, what is most important to you?

_____

_____

9. Are you aware of anything that might prevent you from having either basic or cosmetic dental treatment? ❑ yes ❑ no

10. Have all your past dental office experiences been positive? ❑ yes ❑ no
    If NO, please explain: _____
    _____

11. Is there anything in particular that you would like us to always do for you? ❑ yes ❑ no
    If YES, please explain: _____
    _____

12. Is there anything in particular that you would like us never to do? ❑ yes ❑ no
    If YES, please explain: _____
    _____

13. Do you have any dental concerns not listed here that you would like to bring to our attention? ❑ yes ❑ no
    If YES, please explain: _____
    _____

Thank you for taking the time to complete this form!

Patient_____

FINANCIAL / INSURANCE GUIDELINES

We believe that all patients deserve, from us, the very best dental care we can provide. Further, we believe that everyone benefits when definite financial arrangements are clear and agreed on before treatment is started. We would like to share with you our payment guidelines and methods of payment available. Please let us know which financial options works best for you.

* CASH OR CHECK

Receive a 5% bookkeeping courtesy by paying your appointment with cash or check only. We accept cash, check, Mastercard, Visa, Discover, and American Express to allow you the most convenience in taking care of your account.

* MONTHLY PAYMENT OPTION

We've made special arrangements with a third party financing company to allow you to complete your dental treatment with comfortable monthly payments. CareCredit information will be provided and one of our team members will be happy to assist you and explain how the program works.

We require payment in full for all dental services to be rendered on that day. We can prioritize treatment, so those patients who do not have dental benefits and are on a tight budget can still complete their dental work by spreading appointments over several months. We are happy to discuss this option with you. Please be aware that there are situations where this option may not be available depending on your particular dental conditions and needs.

* REGARDING INSURANCE

As a courtesy to you, we will file your insurance for you. Please keep in mind that if your insurance will cover a portion of your treatment, this benefit will be paid and mailed DIRECTLY TO YOU. Any questions or concerns with your insurance company will be between you and them. Our office will be happy to provide you with the information you may need if the situation arises. I understand that I am fully responsible for any and all charges remaining on my account if and when my insurance company has reimbursed me directly. I have read and fully understand the above policy. I realize that I am financially responsible for all charges whether they are covered by my insurance or not.

*** CANCELLATION POLICY:** All cancellations within 24 hours of appointment immediately receive a cancellation charge of $75. **We do require confirmation of all hygiene appointments**. If appointments are not confirmed with this office within ONE WEEK of the schedule appointment, the appointment will be removed from the schedule and you will be on a short-call list unless you call to reschedule. This is acknowledged by my initials below.

_____ _____

SIGNATURE DATE

NOTICE OF PRIVACY PRACTICES RELEASE

R. David Brumbaugh, DDS
8222 Douglas Avenue, Suite 580
Dallas, TX 75225
214.369.5159 (O)
214.520.8922 (F)
info@drdavidbrumbaugh.com

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name Patient Date of Birth:

I, _____ authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released:

2. To whom may the information be released [name(s) or class(es) of recipients]:

3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

We may receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

DATED_____ PATIENT SIGNATURE_____

R. David Brumbaugh, D.D.S.
Restorative and Cosmetic Dentistry

Sleep Screening Questionnaires

Please answer the questions below to help us assess for possible obstructive sleep apnea (OSA), a condition in which your breathing pauses or stops for periods of time while you sleep. Sleep apnea can increase your risk for many health conditions. It can also increase your risk for breathing problems after surgery.

Name _____ Date _____

DOB _____ Height _____ Weight _____

	Yes	No
Have you ever been diagnosed with OSA?	☐	☐
Are you currently being treated for OSA?	☐	☐
Are you aware of a family history of OSA?	☐	☐
Are you aware of clenching or grinding your teeth at night?	☐	☐

ESS: Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

0 = I would never doze
1 = I have a slight chance of dozing
2 = I have a moderate chance of dozing
3 = I have a high chance of dozing

Situation	Chance of Dozing
1. Sitting and reading	_____
2. Watching TV	_____
3. Sitting inactive in a public place (e.g. a theatre or a meeting)	_____
4. As a passenger in a car for an hour without a break	_____
5. Lying down to rest in the afternoon when circumstances permit	_____
6. Sitting and talking to someone	_____
7. Sitting quietly in a lunch without alcohol	_____
8. In a car while stopped for a few minutes in traffic	_____

STOP - BANG

			Yes	No
1.	Snore	Do you snore loudly? (Louder than talking or loud enough to be heard behind a closed door?	☐	☐
2.	Tired	Do you often feel tired, fatigued or sleepy during daytime?	☐	☐
3.	Obstruction	Has anyone observed you stop breathing during your sleep?	☐	☐
4.	Pressure	Do you have or are you being treated for high blood pressure?	☐	☐
5.	BMI	Is your body mass index greater than 28?	☐	☐
6.	Age	Are you 50 years old or older?	☐	☐
7.	Neck	Males: Is your neck circumference greater than 17 inches? Females: Is your neck circumference greater than 16 inches?	☐	☐
8.	Gender	Are you a male?	☐	☐

_____
Patient Signature

Adapted from www.EpworthSleepinessScale.com and Chung F, et. al Anesthesiology 2008; 108(5):812-821.

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