WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 About You

Today's Date: ______________

E-mail Address: ______________

Name: ______________

I prefer to be called: __________ ❑M ❑F ❑Non-binary

Birthdate: __/__/__ Age: ____ SS #: ______________

Home Address: ______________

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Hm #: (____)__________ Cell #: __________

Wk #: (____)__________ Ext: ___ DL #: __________

Employer: ______________

Employer's Address: ______________

How long there? ________ Occupation: __________

Where & when are the best times to reach you? __________

Whom may we Thank for referring you? __________

Other family members seen by us: __________

Previous / Present Dentist: __________

Last Visit Date: __________

2 Spouse Information

His / Her Name: ______________

Employer: ______________

Wk #: (____)__________ Ext: ___ SS #: __________

Birthdate: __/__/__ DL #: __________

Person Responsible for Account: __________

Wk #: (____)__________ Ext: ___ Hm #: (____)__________

Billing Address: __________

Relation: __________ SS #: __________

Employer: __________ DL #: __________

3 Dental Insurance

Primary Dental Insurance

Insurance Co. Name: ______________

Insurance Co. Address: ______________

Insurance Co. Phone #: (____)__________

Group # (Plan, Local or Policy #): __________

Insured's Name: __________ Relation: __________

Insured's Birthdate: __/__/__ Insured's ID #: __________

Insured's Employer: __________

Secondary Dental Insurance

Insurance Co. Name: ______________

Insurance Co. Address: ______________

Insurance Co. Phone #: (____)__________

Group # (Plan, Local or Policy #): __________

Insured's Name: __________ Relation: __________

Insured's Birthdate: __/__/__ Insured's ID #: __________

Insured's Employer: __________

4 Medical History

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: __________

Phone #: (____)__________ **Last Visit Date:** ______

Are you currently under the care of a physician? ❑ Yes ❑ No

Please Explain: __________

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: __________ Relation: __________

Wk #: (____)__________ Hm #: (____)__________

CONTINUED ON BACK

5 Medical History
continued

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Do you smoke or use tobacco in any form? ❑ Yes ❑ No

Are you taking any prescription/over-the-counter or herbal supplement drugs? ❑ Yes ❑ No

Please list each one: ______________________

Have you ever taken Fosamax, or any other bisphosphonate? ❑ Yes ❑ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ❑ Yes ❑ No

For Women:

Are you using a prescribed method of birth control? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Week #: ________

Are you nursing? ❑ Yes ❑ No

Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding	Y	N	Hepatitis
Y	N	Alcohol / Drug Abuse	Y	N	Herpes / Fever Blisters
Y	N	Anemia	Y	N	High Blood Pressure
Y	N	Arthritis	Y	N	HIV+ / AIDS
Y	N	Artificial Bones / Joints / Valves	Y	N	Hospitalized for Any Reason
Y	N	Asthma	Y	N	Kidney Problems
Y	N	Autism	Y	N	Liver Disease
Y	N	Blood Transfusion	Y	N	Low Blood Pressure
Y	N	Cancer / Chemotherapy	Y	N	Lupus
Y	N	Colitis	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Pacemaker
Y	N	Covid-19	Y	N	Psychiatric Treatment
Y	N	Diabetes	Y	N	Radiation Treatment
Y	N	Difficulty Breathing	Y	N	Rheumatic /Scarlet Fever
Y	N	Emphysema	Y	N	Seizures
Y	N	Epilepsy	Y	N	Shingles
Y	N	Fainting Spells	Y	N	Sickle Cell Disease
Y	N	Frequent Headaches	Y	N	Sinus Problems
Y	N	Glaucoma	Y	N	Stroke
Y	N	Hay Fever	Y	N	Thyroid Problems
Y	N	Heart Attack	Y	N	Tuberculosis (TB)
Y	N	Heart Murmur	Y	N	Ulcers
Y	N	Heart Surgery	Y	N	Venereal Disease
Y	N	Hemophilia			

Please list any medical condition(s) that you have ever had:

____

Have you been vaccinated for Covid-19? ❑ Yes ❑ No

Type? ______________ Date(s)? ______________

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Penicillin
Y N Codeine	Y N Jewelry / Metals	Y N Tetracycline
Y N Dental Anesthetics	Y N Latex	Y N Other

Please list any other drugs/materials that you are allergic to:

____

____

6 Dental History

Why have you come to the dentist today? ________

____

____

Has your doctor told you that you require antibiotics before dental treatment? ❑ Yes ❑ No

Are you currently in pain? ❑ Yes ❑ No

Have you ever had a serious / difficult problem associated with any previous dental work? ❑ Yes ❑ No

Do you or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do you like your smile? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No

How many times a week do you floss? ______

How many times a day do you brush? ______

Type of bristles? ❑ Hard ❑ Medium ❑ Soft

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

____
Signature **Date**

Payment is due in full at time of treatment unless prior arrangements have been approved.

! Thank you for filling out this form completely. It will enable us to help you more effectively. If you have a question at any time, please ask us. We are happy to help.

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

I verbally reviewed the medical / dental information above with the patient named herein. Initials: ____________ Date: ________

Doctor's comments: ______________________

MEDICAL HISTORY UPDATE

1. Date: __________ Comments: ______________________ Signature: ______________
2. Date: __________ Comments: ______________________ Signature: ______________
3. Date: __________ Comments: ______________________ Signature: ______________

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Dr. Howard D. Brooks, D.M.D.
Dr. Barry M. Brooks, D.D.S.

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

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

- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Communications barriers prohibited obtaining the acknowledgement
- ❑ Individual refused to sign
- ❑ Other (Please Specify)

____
____
____
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This form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

General Dental Treatment Consent Form Brooks Dental

54 Woodside Avenue, Winthrop, MA 02152

1. I authorize dental treatment including necessary or advisable examination, radiographs (x-rays), diagnostic aids or local anesthesia.
2. In general terms, dental treatment may include but is not limited to one or a number of the following:
   - Administration of local anesthesia.
   - Cleaning of the teeth and application of topical fluoride.
   - Scaling and root planing with local anesthesia.
   - Application of sealants to the grooves of the teeth.
   - Treatment of diseased or injured teeth with dental restorations. These restorations may either be amalgam (silver) or composite (white).
   - The replacement of missing teeth with a dental prosthesis (crown, partials, etc.).
   - Treatment of diseased or injured oral tissues (hard and/or soft).
   - Treatment of malposed (crooked) teeth and/or developmental abnormalities.
   - Treatment of the canal or pulp chamber that lies in the middle of the tooth and its root also known as "endodontic" therapy or (root canal treatment).

Risks of Dental Procedures in General

Included (but not limited to) are complications resulting from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness, and tingling sensations in the lip, tongue, chin, gums, cheeks and teeth, thrombophlebitis (inflammation to a vein), reaction to injections, change in occlusion (biting), muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of teeth or restoration in teeth, injury to other tissues, referred pain to the ear, neck and head, nausea, allergic reactions, itching, bruises, delayed healing, sinus complications, and further surgery. Medication and drugs may cause drowsiness and lack of awareness and coordination (which can be influenced by the use of alcohol or other drugs), thus it is advisable not to operate any vehicle or hazardous device, or work for twenty-four hours or until recovered from their effects.

Changes in Treatment Plan

I understand that during treatment, it may be necessary to change and/or add procedures because of conditions found while working on the teeth that were not discovered during examination. Upon my consent, I will give my permission to the dentist to make any/all changes and additions as necessary.

Fillings

I understand that I may experience hot and cold sensitivity, pain or discomfort following routine restorative procedures and that this is usually temporary and should settle without further treatment. If in the event that my condition does not get any better, I understand that I may need further dental treatment, the most common being root canal therapy, resulting in additional costs.

Crown (Caps) and Bridges, **Onlays**

I understand that sometimes it is not possible to match the color of artificial teeth with natural teeth. I further understand that I may be wearing temporary crowns, which my come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown or bridge (including shape, fit size, and color) will be before cementation. Once cemented, I understand that any changes in shape, fit, size, or color will incur an additional charge. Upon removal of crowns/veneers, I understand that stumps of teeth may be compromised requiring root canals, periodontal treatment, or extraction that would thus change treatment and incur additional costs.

Alternative Treatment

I understand that I have the right to choose, on the basis of adequate information, from alternate treatment plans that meet professional standards of care.

By signing below, I consent to the general dental treatments and/or proposed treatment.

Patient/Guardian Signature: ______________________________ Date: ______________

Patient Name (Printed): ______________________________

Brooks Dental, P.C.
54 Woodside Avenue
Winthrop, MA 02152
617-846-1811

Office Financial Guidelines:
Thank you for choosing Brooks Dental as your dental health care provider. We are committed to providing you with the highest quality care and service for your dental health needs. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial guidelines. Please read and sign prior to the start of your treatment.

Full payment is due at the time of service.
We accept Cash, Checks, Credit Cards, Care Credit financing (prior credit approval required).

Regarding Insurance:
Co-payment and/or deductible are due at each visit. This may range from 20-50% of your total treatment costs at the time of service. Some insurance companies have a set fee schedule and your out of pocket expense may be higher. All insurance companies have a yearly "maximum covered" amount. It is your responsibility to be aware of that amount and to contact your insurance company if payment is delayed or not paid. The balance is your responsibility whether your insurance pays the estimated amount or not. We cannot submit your claims unless you bring in all insurance information. If your insurance company has not paid your account in full within 30 days, you should be prepared to do so* Please be aware that some or perhaps all of your services provided may be "non-covered" services.

UCR (usual and customary rate):
Our practice is committed to providing the highest quality dental treatment and care for our patients. We believe that patients should have the right to choose their own dentist and dental treatment that best meets their own criteria. Trusting profit motivated insurance companies to select your practitioner, dictate their fees, and control your dental services is against what we believe to be high quality treatment. Therefore we provide fees that are usual and customary for the high quality service that is provided to our patients. It is required that you pay the bill in full regardless of the insurance company's determination of usual and customary rates.

Minors:
The adult accompanying a minor or the parents (or guardian) are responsible for full payment. Before treatment is rendered for unaccompanied minors, prior financial arrangements must be made, Such as an approved credit plan, cash, check, or credit card.

Missed Appointments:
Unless changed at least 24 hours in advance, our guidelines are to charge for missed appointments at a rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

Consent to Contact (cell phone calls/texts and emails)
By providing your cell phone number and/or email you consent to receiving such calls or electronic communication at those sites, including but not limited to communication attempts made by automated telephone systems. This consent by Provider and any affiliates, including any and all third party entities hired by Provider for billing, collections, or customer care services.

Thank you for understanding our financial guidelines. Please let us know if you have any questions.
I have read, understand, and agree to the above financial guidelines.

Patient or responsible party:____________________________________ Date:__________________

*Balances outstanding in excess of 90 days are subject to a late payment charge of 1.5% monthly.