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

Office Financial Guidelines:

Thank you for choosing us as your dental health care provider. We are committed to providing you with the highest quality service and the best treatment possible. 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 treatment.

Full payment is due at the time of service.

We accept Cash, Checks, Credit cards and The Dental Fee Plan (extended payment plan with prior credit approval).

Regarding Insurance:
Full payment is due at your first visit. Assignment of insurance benefits is accepted at the second visit, however, we require that 20-50% of the total bill be paid at the time of service. The balance is your responsibility whether your insurance pays or not. We cannot submit your claim 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 and 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 possible 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 the fees, or limit your 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.

Thank you for understanding our financial guidelines. Please let us know if you have any questions.

I have read, understood 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

CHILD'S REGISTRATION AND HISTORY

Date

Child's name | Nickname | Age | Birthdate

Residence address | City | State | Zip

School | Address | Grade

Father's name | Mother's name

Father employed by | How long | Home phone | Bus. phone

Mother employed by | How long | Home phone | Bus. phone

Person financially responsible (If other than parent) | Relationship to child

Address | City | State | Zip | Phone

Father's Social Security number | Driver license no. | State

Mother's Social Security number | Driver license no. | State

Father's birthdate | Mother's birthdate

Credit card name | No. | Expiration date

When dental insurance coverage name of carrier

Secondary insurance coverage, if any

Whom may we thank for referring you

What is child's favorite: sport | toy | hobby | person | fictional character

DENTAL HISTORY

Date of last visit to a dentist ____________

For what service ____________

	Yes	No
Has child complained about dental problems ____________	☐	☐
Any unhappy dental experiences ____________	☐	☐
Any injuries to mouth - teeth - head ____________	☐	☐
Any mouth habits - thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifer, etc. ____________	☐	☐
Any unusual speech habits ____________	☐	☐
Any lost teeth ____________	☐	☐
Have missing teeth been replaced ____________	☐	☐
Orthodontic appliances worn now or ever been ____________	☐	☐

	Yes	No
Does your child brush teeth daily ____________	☐	☐
Do you assist child with tooth brushing ____________	☐	☐
How often ____________		
Is dental floss used ____________	☐	☐
How often ____________		
Are disclosing tablets used ____________	☐	☐
Is fluoride taken in any form ____________	☐	☐
Do you desire complete dental service for the child ____________	☐	☐

Child's attitude to dentistry ____________

Summary (for doctor's use) ____________

HEALTH HISTORY

Child's physician ______________________ Address ______________________ Phone ____________

Date of last physical examination ______________________ Results ______________________

	Yes	No		Yes	No
Is child under care of physician now ____________	☐	☐	Does child have good physical coordination ____________	☐	☐
Is child receiving any medication or drugs ____________	☐	☐	Are there any emotional problems ____________	☐	☐
Is there any excessive bleeding when cut ____________	☐	☐	Summary (for doctor's use) ____________		
Has child ever been hospitalized ____________	☐	☐			
Has child ever had surgery ____________	☐	☐			
Is there any allergy to penicillin or other drugs ____________	☐	☐			
Are there other allergies: food - pollen - animals - dust - other	☐	☐			

Has child any history of or difficulty with any of the following:

__ Anemia	__ Chronic sinus	__ Hearing	__ Mastoid	__ Thyroid
__ Asthma	__ Convulsions	__ Heart	__ Measles	__ Tuberculosis
__ Bladder	__ Diabetes	__ Kidney	__ Mononucleosis	__ Venereal disease
__ Cerebral Palsy	__ Epilepsy	__ Liver	__ Mumps	__ Other
__ Chicken pox	__ Fainting	__ Malignancies	__ Rheumatic fever	

Summary: (for doctor's use)

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed.

May we request release of your child's medical records for our reference ____________ Yes ☐ No ☐

This information was discussed with and given by ______________________

Relation to child ______________________

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.

About You

Today's Date: _______ **E-mail Address:** ___________

Name: ______________________________

I prefer to be called: ________________ ❑ Male ❑ Female

Birthdate: __/__/__ Age: _____ SS #: ____________

Home Address: ______________________________

____

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Hm #: (____)____________ Pager / Other #: __________

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: ______________________________

Spouse Information

His / Her Name: ______________________________

Employer: ______________________________

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

Birthdate: __/__/__ DL #: ______________

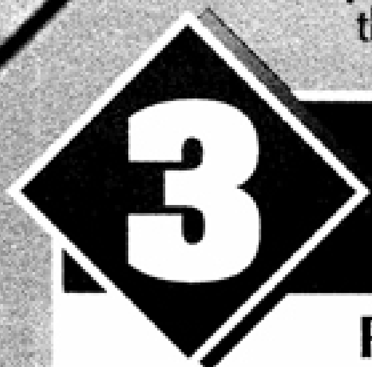
Person Responsible for Account: ______________

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

Billing Address: ______________________________

Relation: ____________ **SS #:** ______________

Employer: ____________ **DL #:** ______________



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 SS #: __________

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 SS #: __________

Insured's Employer: ______________________________

Medical History

Do you have a personal physician? ❑ **Yes** ❑ **No**

Physician's Name: ______________________________

Phone #: (____)____________ **Last Visit Date:** ________

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

His / Her Name: ______________ Relation: __________

Wk #: (____)____________ Hm #: (____)____________

5 Medical History
continued

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

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

Please Explain: ______________________

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

Please list each one: ______________________

____

Have you ever taken Phen-Fen? ❑ Yes ❑ No

(Also known as Redux or Pondimin) If yes, when? ______________________

For Women: Are you taking birth control pills? ❑ 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	Blood Transfusion	Y	N	Liver Disease
Y	N	Cancer/ Chemotherapy	Y	N	Low Blood Pressure
Y	N	Colitis	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Pacemaker
Y	N	Diabetes	Y	N	Psychiatric Problems
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Emphysema	Y	N	Rheumatic /Scarlet Fever
Y	N	Epilepsy	Y	N	Seizures
Y	N	Fainting Spells	Y	N	Shingles
Y	N	Frequent Headaches	Y	N	Sickle Cell Disease
Y	N	Glaucoma	Y	N	Sinus Problems
Y	N	Hay Fever	Y	N	Stroke
Y	N	Heart Attack	Y	N	Thyroid Problems
Y	N	Heart Murmur	Y	N	Tuberculosis (TB)
Y	N	Heart Surgery	Y	N	Ulcers
Y	N	Hemophilia	Y	N	Venereal Disease

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

____

____

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 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:** __________