

GREENBRIAR DENTAL CARE

Please complete the following confidential form

NAME

LAST _____ FIRST _____ MI _____ SALUTATION _____ TITLE _____ MARRIED SINGLE CHILD OTHER

PARENTS NAME IF PATIENT IS A MINOR

_____/_____/_____
PARENTS SSN

_____/_____/_____
DATE OF BIRTH

_____/_____/_____
BIRTHDAY

AGE _____ SOCIAL SECURITY # _____ OTHER ID _____ DRIVERS LICENSE # _____

ADDRESS

STREET _____ apt _____ CITY _____ STATE _____ ZIP CODE _____

PHONE

HOME _____/_____/_____ WORK _____/_____/_____ EXT _____ E-MAIL ADDRESS _____

FAX _____/_____/_____ CELL _____/_____/_____

<p>PRIMARY INSURANCE</p> <p>COMPANY _____</p> <p>GROUP _____</p> <p>GROUP # _____</p> <p>SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/></p> <p>SUBSCRIBERS NAME _____</p> <p>SUBSCRIBERS SSN _____ / D.O.B. _____</p> <p>SUBSCRIBERS EMPLOYER _____</p>	<p>EMPLOYER</p> <p>COMPANY _____</p> <p>ADDRESS _____</p> <p>CITY _____</p> <p>STATE _____</p> <p>ZIP _____</p> <p>MEDICAL INSURANCE</p> <p>COMPANY _____</p> <p>GROUP# _____</p>
<p>SECONDARY INSURANCE</p> <p>COMPANY _____</p> <p>GROUP _____</p> <p>GROUP # _____</p> <p>SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/></p> <p>SUBSCRIBERS NAME _____</p> <p>SUBSCRIBERS SSN _____</p> <p>SUBSCRIBERS EMPLOYER _____</p>	<p>REFERRAL</p> <p><input type="checkbox"/> PATIENT _____</p> <p><input type="checkbox"/> INS COMPANY _____</p> <p><input type="checkbox"/> YELLOW PAGES _____</p> <p><input type="checkbox"/> SIGN / LOCATION _____</p> <p><input type="checkbox"/> OTHER _____</p> <p>HOW DO YOU PLAN TO PAY FOR YOUR TREATMENT?</p> <p>CASH <input type="checkbox"/> CHECK <input type="checkbox"/> MC/VISA <input type="checkbox"/> AMEX <input type="checkbox"/></p>

CONSENT

The undersigned hereby authorizes the doctor(s) and/or designated staff of Greenbriar Dental Care, P.C. to perform whatever dental treatment, dental operation, diagnostic aids and tests, or any other procedure deemed necessary or appropriate by the doctor(s) to make a thorough diagnosis of the patient's dental needs. Upon such diagnosis, I authorize Greenbriar Dental Care, P.C. to perform all recommended treatment mutually agreed upon by me and employ such assistance as required to provide proper care. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk. I authorize my insurance benefits to be paid directly to Greenbriar Dental Care, P.C. and I authorize the release of any information required.

I understand that Greenbriar Dental Care, P.C. will file my insurance claims as a service to me, but that I am responsible for all amounts not paid by the insurance company for any reason. Should my insurance company(ies) fail to pay within 90 days, for any reason, I will be expected to remit payment in full. I further understand that a finance charge(18%) will be added to any overdue balance. If collection and/or legal service are required to obtain payment of the amount billed, I further agree to pay for all legal costs reasonably incurred in connection therewith.

Patient (or responsible party) _____ Date ___/___/___

MEDICAL HISTORY

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT THE PRESENT:

RHEUMATIC FEVER CONGENITAL HEART DEFECT CHEST PAIN (ANGINA) CONESTIVE HEART FAILURE HEART (SURGERY, DISEASE, ATTACK) ARRYTHMIA HEART MURMUR MITRAL VALVE PROLAPSE PACEMAKER ARTIFICIAL HEART VALVE HIGH BLOOD PRESSURE STROKE KIDNEY DISEASE LIVER DISEASE/SURGERY EPILEPSY/SEIZURES DIABETES	LATEX ALLERGY ASTHMA EMPHYSEMA BRONCHITIS HAY FEVER/SINUSITIS TUBERCULOSIS (TB) PAIN IN JAW JOINTS ARTIFICIAL JOINTS (KNEE, HIP, ETC.) HEPATITIS (TYPE)____ (DATE)____ HEMOPHILIA IMMUNOLOGY DISORDERS A.I.D.S./HIV FAINTING/DIZZY SPELLS NEUROLOGICAL DISORDERS PSYCHIATRIC/ PSYCHOLOGICAL DISORDERS
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ARE YOU HAVING ANY PAIN OR DISCOMFORT AT THIS TIME? YES NO

HAVE YOU BEEN UNDER THE CARE OF A HOSPITAL, MEDICAL DOCTOR, PSYCHIATRIST OR PSYCHOLOGIST DURING THE LAST THREE YEARS? YES NO

IF YES, FOR WHAT CONDITION? _____
 PHYSICIANS NAME _____ PHONE _____
 ADDRESS _____

ARE YOU TAKING ANY MEDICATION, DRUGS OR PILLS NOW? YES NO

IF YES, PLEASE LIST THE NAME AND DOSAGE _____

ARE YOU AWARE OF HAVING AN ALLERGIC REACTION (OR ADVERSE REACTION) TO ANY SUBSTANCE? YES NO

IF YES, PLEASE LIST _____

DO YOU HAVE OR HAVE YOU HAD ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED? YES NO

IF YES, PLEASE LIST _____

FOR WOMEN ONLY ARE YOU:

PREGNANT? YES,(___) MONTHS NO NURSING? YES NO TAKING BIRTH CONTROL PILLS YES NO

I UNDERSTAND THE ABOVE INFORMATION IS NECESSARY TO PROVIDE ME WITH DENTAL CARE IN A SAFE AND EFFICIENT MANNER. I ANSWERED ALL QUESTIONS TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY THE DOCTOR OF ANY CHANGE IN MY HEALTH OR MEDICATION AS SOON AS POSSIBLE.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

MEDICAL ALERT: