Branham Dental Arts
NURTURING HEALTHY SMILES

Patient Information

Date_____ Social Security #_____ Birthdate_____

Name_____ Home Phone_____

Address_____ Cell Phone _____

City _____ State_____ Zip_____ E-mail _____

Sex: □ Male □ Female □ Minor □ Single □ Married □ Divorced □ Widowed

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

Primary Dental Insurance

Person Responsible for Account _____

Relationship to Patient _____ Birthdate _____ Soc. Sec # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____ Insurance Company Address_____

Subscriber I.D. # _____ Group # _____

Dental History

Former Dentist _____ Date of Last X-Rays? _____
City, State _____ How often do you floss? _____
Date of Last Dental Visit_____ How often Do You Brush? _____

Please check all that apply:

Bad Breath……... ◻
Bleeding Gums……. ◻
Blisters on Lips or Mouth…. ◻
Finger Nail Biting……. ◻
Grinding Teeth……. ◻
Lip or Cheek Biting…….. ◻
Loose Teeth or Broken Fillings… ◻
Orthodontic Treatment …… ◻
Pain Around Ear …… ◻
Periodontal Treatment…… ◻
Sensitivity to Cold…….. ◻
Sensitivity to Hot……. ◻
Sensitive to Sweets……. ◻
Sensitivity When Biting…… ◻
Frequent Headaches…… ◻
Jaw, Head or Neck Injuries... ◻
Jaw Difficulty: Clicking/Pain. ◻
Tooth Pain…….. ◻

Medical History

Physician's Name_____ Date of Last Visit _____

1. Are you currently under medical treatment? _____
2. Have you ever had a serious illnesses/operations? _____
3. Do you smoke? _____
4. Do you use alcohol? _____
5. Do you use drugs? _____
6. Do you wear contact lenses? _____
7. (Women Only) Are You:
   Pregnant? _____
   Nursing? _____
   Taking birth control pills? _____
8. Have you had any allergic reactions to the following?
   Local Anesthetics (Novocain) _____
   Penicillin or other Antibiotics _____
   Sulfa Drugs_____
   Barbiturates (Sleeping Pills) _____
   Sedatives _____
   Iodine _____
   Aspirin _____
   Other _____
9. Please list current medication:

_____
_____
_____
_____
_____

Please check all that apply:

AIDS/HIV…….◻
Anemia…….....◻
Arthritis, Rheumatism…… ◻
Artificial Heart Valves…… ◻
Artificial Joints…….……..... ◻
Asthma…….◻
Back Problems…….....◻
Bleeding Abnormally,
With extractions or surgery……. ◻
Blood Disease……..…… ◻
Cancer……...…….. ◻
Chemical Dependency…… ◻
Chemotherapy……..….. ◻
Chronic Fatigue Syndrome……. ◻
Circulatory Problems…….. ◻
Congenital Heart Lesions……... ◻
Cortisone Treatments……..…...◻
Cough-persistent or bloody….…… ◻
Diabetes…….….. ◻
Emphysema…… ◻
Pacemaker…… ……. ◻
Epilepsy…… ◻
Fainting/Dizziness……..... ◻
HIV Positive…… ◻
Headaches…….. ◻
Heart Murmur…… ◻
Heart Problems……..……... ◻
Hepatitis-Type____…… ◻
Herpes…….....◻
High Blood Pressure……◻
Jaundice……..... ◻
Jaw Pain…….. ◻
Kidney Disease……◻
Latex Sensitivity……..… ◻
Liver Disease……...…... ◻
Low Blood Pressure……..….. ◻
Mitral Valve Prolapse……..…… ◻
Nervous Problems…….. ◻
Pacemaker…….…… ◻
Psychiatric Care…….. ◻
Radiation Treatment…….. ◻
Respiratory Disease…….◻
Rheumatic Fever…… ◻
Scarlet Fever……◻
Shortness of Breath…….....◻
Sinus Trouble……...◻
Skin Rash…….……◻
Stroke…….....◻
Swelling of Feet/Ankles……..... ◻
Swollen Neck Glands……..... ◻
Thyroid Glands……...◻
Tonsillitis……◻
Tuberculosis……..…….. ◻
Tumor or growth on head/neck…... ◻
Ulcer……...…… ◻
Venereal Disease…….…… ◻

I hereby authorize payment directly to Branham Dental Arts for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

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GENERAL CONSENT FORM

Patient Name: _____
Last First Middle

Patient Date of Birth: _____
Month Day Year

1. **I freely consent to dental care –** which may include procedures, treatment options, tests, drugs, and treatments that I may receive at Branham Dental Arts, P.C. I know that I have a right to consent or refuse to consent to any future surgery, procedure or treatment and to discuss it with my health care provider. I know I will be informed of all reasonable treatment options. I know that the practice of dentistry is not an exact science and outcomes may be different for each patient.

2. **I know that my health care records will be used for my diagnosis, treatment planning, treatment, and for billing for services.** I know that Branham Dental Arts, P.C. will do everything possible to keep my records private, and that it is Branham Dental Arts, P.C. policy to provide access to health care and billing records only on the basis of need to know. A copy of Branham Dental Arts, P.C. privacy statement has been given to me, and that additional copies are available if I ask a member of the staff for one.

3. **I agree that Branham Dental Arts, P.C. can release data about protective health information to: (A) Health care providers** for the purpose of helping with future care and treatment. **(B) Third party payers** such as insurance groups, Medicare, Medicaid, and their agents. This also includes those who may be in charge of any part of payment for costs linked to my treatment. **(C) Lawyers** who work for or on behalf of Branham Dental Arts, P.C.; **(D) Regulatory agencies; (E) Federal or state agencies as required by law.**

4. **I know that in the course of diagnosis and treatment, body tissues, fluids, and other samples may be taken.** Branham Dental Arts, P.C. may dispose of my body tissues, fluids and other samples in a fitting way without cost to me.

5. Human Immunodeficiency Virus (HIV) is the virus that causes AIDS (Acquired Deficiency Syndrome). **I know that under Michigan law, an HIV blood test may be done on a patient if any health care worker or emergency responder contacts that patient's blood or any other body fluids through the skin, in an open wound, or through the mucous membranes.** If this type of contact occurs, I know that I may be asked to take a blood test. However, I do have a right to refuse. If a test is done, I know that I will be informed of the test results, I will receive advice about what to do, what the results mean and what treatment, if any, is indicated if I so choose.

6. Except as barred by any agreement between my insurance company and Branham Dental Arts, P.C. or by state or federal law, **I agree to be responsible for my co-payments, deductibles or other charges for dental or medical services not covered or paid by Insurance or other third party payers. I permit Branham Dental Arts, P.C. to file claims with third party payers for payment and assign all rights and benefits to Branham Dental Arts, P.C. as fitting.** I will help Branham Dental Arts, P.C. to follow up on these claims. I further agree - subject to state and federal law – to pay all costs, lawyer fees, expenses, and interest in the event Branham Dental Arts, P.C. has to take action to collect for services not covered by insurance or other third party payers because of my failure to pay for these services.

7. **I know that a HIPAA Privacy and Security policy letter has been given to me and I understand its contents. I know that if I have any concern regarding my dental care, treatment plan, or financial obligations; I will have access to a health care provider or business person who will answer my questions.**

I confirm that I have read and understand this form, or that it has been read and explained to me. I know the contents and agree with the terms in this form. I know this form is valid for care given by Branham Dental Arts, P.C. until it is revoked by my legal representative or me.

Name of Patient	Signature of Patient	Date

Name of Parent or Guardian	Signature of Parent or Guardian	Date

Relationship to Patient (if Patient under 18 years of age)

Witness Name	Signature of Witness	Date

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SHARED COMMITMENTS

THREE IMPORTANT POLICIES

A policy is a written statement, which determines actions or activities of an organization. We have three important policies in our practice that we feel are important to share with you, our patient. We have put them into writing because we live by them and require that all our patients live by them as well. We realize that the institution of these three policies may be different from what you may be accustomed to in the past; however, we believe that they are very necessary. We ask you to read this page thoroughly and then sign it in the presence of the doctor or staff member to indicate that you understand these policies and agree to comply with them.

COMMITMENT TO TREATMENT POLICY

We believe that all treatment begun should be completed. Incomplete treatment leads to problems, complications, and misunderstandings. Incomplete treatment leads to loss of teeth and further disease. Therefore, this policy states that all agreed to treatment plans, once they are started, will be complete. Some treatment plans because of their design, take years to complete. However, to begin staged treatment, your commitment to both starting and completing treatment is required.

COMMITMENT TO APPOINTMENT POLICY

We reserve time for each patient in our practice. Because we know everyone values his or her time, we will do everything in our power to operate on schedule. An appointment written in our schedule with your name on it is a bond of trust that we will be here to serve you and you will be present for that appointment. We ask you to commit to arrive on time for your appointments. We charge for all cancellations made with less than a 48-hour working day notice. We ask that you contact our office directly for any appointment cancellations or changes, our office hours are as follows: M 7:30 a.m. – 5:00, T 7:30 a.m.-8:00p.m. W 9:00 a.m. - 2:00 p.m. TH 12:00p.m.-8:00 p.m., and scheduled one Saturday a month from 7:30 a.m. – 1:00 p.m. Your signature below indicates that we must have mutual respect for each other's time.

COMMITMENT TO FINANCIAL ARRANGEMENTS

We believe that we have a responsibility to use our best professional care, skill and judgement in planning for your dental treatment. The benefits and liabilities of neglect are always explained to you at your Review of Findings consultation. By signing below, you indicate that you agree to fulfill your financial commitment, including reasonable attorney's fees and costs of collection in the event of default, to our office promptly and completely. No business or practice can fulfill its mission to its patients when a bond of trust is violated by failure to pay for services rendered upon completion of treatment. Not living up to this trust violates this important business principle. We accept Cash, Checks, MasterCard, Visa and Discover, as well as Care Credit as forms of payment. If you are fortunate to have dental insurance benefits, we will complete your insurance form and submit it to your insurance company, as a courtesy to you. We are not responsible, however, for what your insurance company chooses to pay or reject. You are ultimately responsible to pay for any services provided to you.

Patient **Date** **Doctor/Staff Member**

_____

Patient Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

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

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)

_____

_____

_____

Photography Agreement and Release

We will be taking some photos during your treatment. Most of these pictures are used for planning, records and lab communication. They are also used to communicate with you about your teeth at different phases of your treatment. However, we may also use them for marketing and/or social media.

We would like to ask your permission to potentially use your photos for articles, advertisements, marketing, office brochures and educational purposes. By signing this agreement, you are giving us your permission to use the photos that we take.

Thank You!

Signed_____ Date:_____