Se habla español

For language assistance services, free of charge, please visit www.freetranslation.com.

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Our practice is based on preventive care. If you have any questions, please feel free to ask.
PLEASE FILL OUT THIS FORM IN ITS ENTIRETY IN INK.

1. ABOUT YOU

Name: _____
Preferred Name: _____
Gender: ☐ Male ☐ Female
Date of Birth: _____ Age: _____
Social Security Number: _____
Mailing Address: _____
_____
Home Phone Number: _____
Best Daytime Phone Number: _____
Email Address: _____
Employer: _____
Occupation: _____ # Years: _____
Work Phone: OK to call?

2. ABOUT YOUR FAMILY

Spouse/Other: _____
Mailing Address: _____
_____
How long at this address? _____
Home Phone Number: _____
Best Daytime Phone Number: _____
_____
SSN: _____ DOB: _____
Employer: _____
Occupation: _____ # Years: _____
Work Phone: _____ OK to call? _____
List Children's names and ages: _____
_____

IN CASE OF EMERGENCY, WHOM SHOULD WE NOTIFY?

Name (other than yourself): _____
Best Daytime Phone Number: _____
Relationship to patient: _____
Complete Address: _____

3. ABOUT PAYMENT

Are you covered by dental insurance? _____
Policy Holder's Name: _____
Address: _____
_____
SSN: _____ DOB: _____
Dental Insurance Co. Name: _____
Group #: _____ Effective Date: _____
Employer: _____
Relationship to patient: _____
Method of payment not covered by insurance:
☐ Cash ☐ Check ☐ Credit Card

4. GENERAL INFORMATION

Reason for seeking care: _____
_____
How did you hear about us? _____
_____
Has this office rendered treatment to any other family members? _____
List names and relationship to patient: _____
_____

DENTAL HISTORY

5. Previous dentist's name and address: _____
Date of last visit: _____ Treatment Rendered: _____
Have you experienced any unfavorable reactions from dental or medical care? _____
If yes, please specify: _____

6. Please mark any of the following you have now or have had in the past:

☐ Abscess or gum boil	☐ Cold Sore or Fever Blisters	☐ Injury to front teeth/jaw/mouth/face
☐ Mouth breathing	☐ Orthodontic Treatment	☐ Clenching/Grinding teeth
☐ TMJ/Jaw problems	☐ Bleeding gums	☐ Other: _____

7. How many times are you brushing daily? _____ Type of toothpaste used? _____
Flossing? ☐ Daily ☐ Sometimes ☐ Never

Is there anything about the appearance of your teeth that you would like to discuss? _____
If yes, please specify: _____

8. Do you have any health problems? YES NO
If yes, please specify: _____

Are you taking any medications or drugs (including non-prescription medications) at this time? YES NO
If yes, please specify: _____

_____

Do you smoke or use tobacco products? YES NO
If yes, please specify frequency of use: ☐ Often ☐ Occasionally ☐ Other: _____

Do you consume alcohol? YES NO
If yes, please specify frequency of use: ☐ Often ☐ Occasionally ☐ Other: _____

Do you have any allergies to drugs, medicines, latex rubber, or metals? YES NO
If yes, please specify: _____

Have you ever been hospitalized, had surgery or an operation? YES NO
If yes, please specify: _____

9. **Please circle any of the following that you have now or have had in the past:**

Abnormal Bleeding/Blood Disorder	Epilepsy	Nutritional Deficiency
AIDS/Immunosuppressive Disorder	Eye Problems	Orthopedic Problems
Anemia	Fainting	Pneumonia
Allergies	Hearing Loss	Pregnancy
Artificial Joints, Implants, Valves	Heart Disease/Heart Murmur	Psychiatric Disorder
Asthma	Hemophilia	Rheumatic Fever
Autism	Hepatitis/Jaundice	Scoliosis
Brain Injury	High or Low Blood Pressure	Sickle Cell Anemia
Cancer/Tumors	Hyperactivity	Spina Bifida
Cerebral Palsy	Kidney/Liver Problems	Stomach Trouble/Ulcers
Cleft lip/Palate	Leukemia	Stroke
Convulsions/Seizures	Lung Disease	Syndrome: _____
Diabetes	Mental Retardation	Received Blood Transfusion
Emotional Problems	Mumps	Tuberculosis
Endocrine Disorders	Muscle Disorders	VD (syphilis or Gonorrhea)
Chemotherapy	Muscular Dystrophy	Other: _____

Comments: _____

10. Name of physician: _____
Address: _____ City: _____ State: _____
Date of last physical examination: _____
Is there any other information about your health that we should know? _____

AUTHORITY TO TREAT

I acknowledge that the above information is correct. I hereby consent to and authorize the doctor to perform any and all forms of treatment, medication, therapy and patient management techniques that may be indicated in connection with my dental care and further authorize and consent that the doctor selects and uses such assistance as he deems necessary. I understand that the diagnosis of services needed and full explanation of the procedure(s) involved will be given by the doctor and/or his staff before treatment is rendered. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to pay for all services rendered by this office. If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this account or any future outstanding account balances. I understand that where appropriate, credit bureau reports may be obtained. I consent to receiving calls and text messages from this office via automated telephone dialing systems, and /or prerecorded messages.

Signature _____ **Date** _____

Doctor Signature: _____

OFFICE USE ONLY

WHAT YOU CAN EXPECT FINANCIALLY

BRUSH PEDIATRIC & FAMILY DENTISTRY
Chris Fagan, DDS, PLLC

Thank you for choosing us as your and/or your child(ren)'s dental provider. Our main concern is that you and/or your child(ren) receive the proper and optimal treatments needed to promote exceptional dental health.

Payment is due at the time of service. We **will not** bill a second party; therefore, **you are responsible for full payment at your appointment, or if you are a parent or guardian bringing a child to an appointment, you are responsible for full payment**. We accept **cash, personal checks, payment(s) in advance, MasterCard, Visa, Discover, American Express and outside dental financing (upon approval).** If you do not have insurance, please proceed to the "Other things you need to know" section. If you have insurance, we will file your insurance claim for you, if you commit to the following:

1. You provide current insurance information and advise us of any changes in coverage BEFORE the next appointment.

2. Our practice is committed to providing the best treatment for our patients. Our fees reflect what is usual and customary for our area. Each insurance company, however, makes arbitrary determinations of what they choose as "usual and customary" rates. You are responsible for all amounts not paid by your insurance company. If your insurance company has not responded with payment after 45 days, we will contact you to assist in payment.

3. We are NOT a party to any insurance contract. Our relationship is with you, not your insurance company.

4. Because all insurance plans differ, it is difficult to estimate what, if any, your secondary insurance may pay. Therefore, we DO NOT use secondary coverage to calculate your estimated co-pay.

5. The insured hereby instructs and directs the insurance company to pay by check, or by electronic funds transfer, made out and mailed to Chris Fagan, DDS, PLLC. If the insurance company's current policy prohibits direct payment to the doctor, then the insured hereby also instructs and directs the insurance company to make out the check to Chris Fagan, DDS, PLLC or Brush Dental and mail as follows: C/O Chris Fagan, DDS, PLLC.

Other things you need to know: Account balances that are over 60 days past due will be subject to additional collection fees and billing charges. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the best management of your account and to continue to maintain the best possible relationship with you. Returned checks or automatic drafts are subject to a $25.00 fee.

Respect for appointments: We ask for your cooperation in keeping scheduled appointments. When an appointment is broken or not kept, three different groups of people suffer:

1st You, or your child(ren), suffer because they do not receive their needed care.
2nd Our other patients suffer since they do not have the opportunity to be seen at that time.
3rd There is an economic loss for our office since our overhead (rent, utilities, salaries, etc.) continue whether you, or your child(ren) are here or not, and we have little opportunity to schedule another patient at that time on short notice.

Therefore, cancelled or broken appointments without at least 24 hour notice to this office will be subject to a broken appointment fee of $50.00 per patient seen by us in your family. After two (2) failed appointments all future appointments must be paid in full prior to you or your child(ren) being seen by Dr. Fagan. _____
initial

As a service to our clients, we provide a courtesy appointment reminder call and possibly other important calls regarding appointment changes, treatment, insurance, and/or your account. By providing your cell phone number, you consent to receiving such calls at that number. By initialing, you understand that you have the right to withdraw your consent at any time. _____
initial

By signing below, you agree that you have read, understand, and agree to this financial/appointment policy.

Signature: _____ Date: _____

Relationship to patient: _____

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