BRUSH PEDIATRIC & FAMILY DENTISTRY
Dr. Tim Fagan | Dr. Chris Fagan | Dr. Lisa Grimes
423 N. Van Buren Enid, OK 73703

READ FIRST

Thank you for scheduling your first appointment with Brush Pediatric & Family Dentistry. We wanted to drop you a quick note to welcome you into our family and to make sure your first visit goes smoothly. Please call our office at **(580) 233-0043** if you have any additional questions about our office or our staff. Our highly trained health care professionals are here to help you in any way they can, need only to ask!

WHAT WE NEED FROM YOU

- Because your time is important to us, we kindly ask that you arrive to your appointment 10-15 minutes early with your paperwork complete. If you are late or your paperwork is not complete, we may not be able to see you.
- We must have your paperwork 24 hours in advance so that our doctors can review your health status and ensure we are prepared for your visit. You are more than welcome to mail your enclosed paperwork, scan or take a picture and email to info@brushenid.com, or drop off your paperwork in our office.
- We've taken every measure to verify your insurance coverage. Please notify us immediately if there are any changes in your insurance. We must have your insurance information before your appointment.
- If you are unable to keep your scheduled appointment, you must contact our office 48 hours in advance. Not showing to or cancelling your appointment within 48 hours takes time away from other patients and may result in dismissal from our office.
- If you are receiving paperwork for multiple members in your family, each member needs the health history paperwork to be completed.
- Because we have many patients to serve in our community, if we are unable to confirm your appointment, you will be removed from our schedule.

Again, thank you for selecting us as your new dental home. We're looking forward to seeing you, and we will do everything we can to make your visit quick and comfortable.

Sincerely,

Your team at Brush Pediatric & Family Dentistry

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost.
To speak to an interpreter, call **855-710-6984**.

CHRIS FAGAN, DDS, PLLC | TIM FAGAN, DDS, MS | LISA GRIMES, DDS
423 N. Van Buren | Enid, OK 73703 | Phone: 580-233-0043 | Fax: 580-233-8571
info@brushenid.com | www.brushenid.com

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.

PATIENT INFORMATION

Child's Full Name: _____ Preferred Name: _____
Gender: ☐ Male ☐ Female Social Security Number: _____ Date of Birth: _____

Parent/Guardian's Full Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____
OK to call work?
Home Phone: _____ Cell Phone: _____ Work Phone: _____ ☐Yes ☐ No
Email Address: _____
Gender: ☐ Male ☐ Female Social Security Number: _____ Date of Birth: _____
Employer: _____

Spouse/Other's Full Name: _____
Spouse/Other Street Address (if different): _____
Spouse/Other City (if different): _____ State: _____ Zip: _____
OK to call work?
Home Phone: _____ Cell Phone: _____ Work Phone: _____ ☐Yes ☐ No
Email Address: _____
Social Security Number: _____ Date of Birth: _____
Employer: _____

IN CASE OF EMERGENCY, WHOM SHOULD WE NOTIFY?
Full Name: _____ Relationship: _____ Phone Number: _____
Street Address: _____ City, State: _____ Zip: _____

HOW DID YOU HEAR ABOUT US?
☐ Drive-by ☐ Phonebook ☐ Facebook ☐ Google ☐ Existing Patient ☐ Other: _____

INSURANCE INFORMATION

Is your child covered by dental insurance? ☐ Yes ☐ No
Dental Insurance Company: ☐ Delta Dental ☐ Blue Cross Blue Shield ☐ HealthChoice ☐ Cigna
☐ SoonerCare ☐ Other: _____
Policy Holder Full Name: _____ Relationship to Patient: _____ ☐ Self
Method of payment for procedures not covered by insurance: ☐ Cash ☐ Check ☐ Credit Card

IF POLICY HOLDER INFORMATION IS THROUGH YOU OR A SPOUSE/OTHER, SKIP TO NEXT SECTION.

Policy Holder Street Address: _____
Policy Holder City: _____ State: _____ Zip: _____
Social Security Number: _____ Date of Birth: _____

DENTAL HISTORY

Reason for seeking care: _____
Previous Dentist Name: _____ City, State: _____
Approximate Date of Last Visit: _____ Treatment Rendered: _____

DENTAL HISTORY CONTINUED

Have they ever experienced any unfavorable reactions from dental or medical care? ☐ Yes ☐ No

If yes, please explain: _____

Breastfed to what age? _____ Bottle-fed to what age? _____ Who brushes their teeth? _____

How many times are they brushing daily? _____ Type of Toothpaste: _____

Flossing? ☐ Daily ☐ Sometimes ☐ Never

Is there anything about the appearance of their teeth that you would like to discuss? ☐ Yes ☐ No

If yes, please explain: _____

PLEASE CHECK ANY OF THE FOLLOWING THEY 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: _____

MEDICAL HISTORY

Do they have any health problems? ☐ Yes ☐ No

If yes, please specify: _____

Are they taking any medications or drugs (including non-prescription medications) at this time? ☐ Yes ☐ No

If yes, please specify: _____

Do they have any allergies to drugs, medicines, latex rubber, or metals? ☐ Yes ☐ No

If yes, please specify: _____

Have they ever been hospitalized, had surgery or an operation? ☐ Yes ☐ No

If yes, please specify: _____

PLEASE CHECK ANY OF THE FOLLOWING THAT THEY 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: _____

Name of Physician: _____ Phone Number: _____

Approximate Date of Last Examination: _____

AUTHORITY TO TREAT

I acknowledge that the above information is correct. I, being the parent, guardian or other person entitled to legal custody of the above mentioned minor child patient, 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 the dental care of the patient and further authorize and consent that the doctor selects and uses such assistance as they deem 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 their 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: _____

RESERVATION POLICY

BRUSH PEDIATRIC & FAMILY DENTISTRY
CHRIS FAGAN, DDS, PLLC | TIM FAGAN, DDS, MS | LISA GRIMES, DDS

Thank you for choosing us as your family's dental provider. Our main concern is that you receive the proper and optimal care needed to promote exceptional dental health.

Because your time is important to us, we kindly ask that you arrive to your appointment 10-15 minutes early with your paperwork complete. If you are late or your paperwork is not complete, we may not be able to see you.

If you are unable to keep your scheduled appointment, you must contact our office 48 hours in advance. Not showing to or cancelling your appointment within 48 hours takes time away from other patients and may result in dismissal from our office.

Because we have many patients to serve in our community, if we are unable to confirm your appointment, you will be removed from our schedule.

A parent or legal guardian must bring a minor patient for all scheduled reservations. If this is not possible, we will need written authorization from the responsible party to perform treatment.

Parents are encouraged to accompany their child into the treatment area on their first visit. If additional reservations are required, parents are asked to remain in the reception area while treatment is provided.

Payment is due at the time of service. We **will not** bill a second party; therefore, **you are responsible for full payment at your reservation**. If you have insurance, we will file your insurance claim on your behalf, if you commit to the following:

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

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.

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

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.

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 encourage you to communicate any temporary financial concerns 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.

If you are needing financial assistance, we offer pre-payment plans. Your portion is required to be paid in full before treatment begins. We accept cash, personal checks, payment(s) in advance, MasterCard, Visa, Discover, American Express and outside dental financing (upon approval) such as Care Credit and Lending Club.

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

By signing below, you agree that you have read, understand, and agree to this reservation policy.

Signature: _____ Date: _____

Relationship to Patient: _____ ☐ Self

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To speak to an interpreter, call 855-710-6984.