

Name: _____ Date: _____

Dental History

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental x-rays _____

Check if you have had problems with any of the following:

- | | |
|--|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding teeth |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Sores or growths in your mouth |
| <input type="checkbox"/> Food collection between teeth | |
| <input type="checkbox"/> Sensitivity to (please circle) COLD / HOT / SWEETS / BITING | |

How often do you floss? _____ How often do you brush? _____

Have you ever been diagnosed or treated for Periodontal (gum) disease? _____

Analyze Your Own Smile Survey

- | | |
|---|-----------|
| 1. Is there anything about your teeth or your smile that you would like to change if possible? | Yes or No |
| 2. Do you cover your mouth with your hand when you smile or talk? | Yes or No |
| 3. Are some of your teeth darker than the others? | Yes or No |
| 4. Do some of your teeth have white or brown stains? | Yes or No |
| 5. Are you self-conscious about smiling in front of other people? | Yes or No |
| 6. Would you like a whiter, more youthful smile? | Yes or No |
| 7. Do you see any defects in the appearance of your teeth or gums? | Yes or No |
| 8. Are there spaces or gaps between any of your teeth? | Yes or No |
| 9. Are your teeth crowded? | Yes or No |
| 10. If you have crowding or spaces, is it getting worse? | Yes or No |
| 11. Are any of your teeth too long or too short? | Yes or No |
| 12. Are any of your teeth crooked, jagged, worn, or chipped? | Yes or No |
| 13. Do you have old fillings or bonding that are chipped, discolored, misshaped, worn, or otherwise in need of replacing? | Yes or No |
| 14. Do you have old veneers or crowns that need improvement? | Yes or No |
| 15. Do you have missing teeth that you would like replaced? | Yes or No |
| 16. If you wear a removable appliance, is it stable and comfortable? | Yes or No |

What is your main concern? _____

If cost were not an issue, what changes would you make in your smile? _____

PAYMENT POLICY

Dr. Brackett DOES NOT participate with any insurance plan. Charges for initial visit, whether examination or emergency, **are payable in full at the time services are rendered.** As courtesy, we will file an insurance claim for reimbursement directly to you or provide you with paperwork to file. We will accept payment directly from your insurance company when applicable. However, **YOU are responsible for any balance not covered by your insurance plan.** Please consult with our business assistant concerning a need for partial payment prior to treatment. Fees not paid within sixty (60) days are subject to a past-due billing charge of \$2.00 or 1.5% per month, whichever is greater. All costs of collection by attorney/collection companies will be your responsibility as well.

RELEASE

I authorize Dr. Brackett to perform diagnostic procedures and treatment as may be necessary for proper dental care. I hereby authorize payment of insurance benefits directly to Dr. Brackett otherwise payable to me. I authorize release of any information concerning my (or my child's) health care, advice and treatment to my insurance company relating to any claims on my (or my child's) behalf. I understand that my dental insurance carrier or payor of my dental benefits may pay less than the actual bill for services. **I understand that I am financially responsible for payment in full of all accounts.** By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid I whole or in part by my dental care payor.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve

the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Website.

AUTHORIZATION FOR DENTAL INSURANCE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Brackett all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Doctor Brackett may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determine insurance benefits or the benefits payable for related services.

EMAIL AND TEXT COMMUNICATION

I agree that the dental practice may communicate with me electronically at the email or text listed on registration form.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address or cell phone number.

I can withdraw my consent to electronic communications by calling 251-981-2273.

ACKNOWLEDGEMENT OF RECIEPT

I acknowledge that I received or read a copy of Dr. John H. Brackett's Notice of Privacy Practices.

Patient Name _____

Signature _____ Date _____

HISTORY MEDICAL for: Name: _____ Birth Date: _____

Your mouth is the first stage of your digestive system. Improper care at this stage can dramatically affect your heart as well. All medical history and medications being taken are critical information to help us treat and maintain your dental health.

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No Please List Medications: _____
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Are you on a special diet? Yes No
- Do you use tobacco? Yes No
- Do you use controlled substances? Yes No
- Women: Are you**

Pregnant/Trying to get pregnant? Nursing?

Taking oral contraceptives?

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa Drugs Milk
- Other If yes, please explain: _____

Do you have, or have you had, any of the following?

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Spinal Bifida |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Herpes | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Venereal Disease |
| | | | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Yellow Jaundice |

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Patient Registration

Today's Date:					
First Name:	Last Name:	Preferred Name:			
Address:		City, State, Zip:			
Date of Birth:	Sex:	Social Security Number: (only if needed for insurance)	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated
			<input type="checkbox"/> Single	<input type="checkbox"/> Widowed	<input type="checkbox"/> Partnered for ____ years
Home Phone:	Cell Phone:	Work Phone:	Occupation:		
E-mail:	Would you like to receive correspondences via e-mail? <input type="checkbox"/> Yes <input type="checkbox"/> No		Can we text message you for appointment alerts? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Whom may we thank for referring you?		Have you visited our Website? <input type="checkbox"/> Yes <input type="checkbox"/> No		www.DOCOFTHEBAY.com	
Preferred Pharmacy:	In case of emergency who should be notified? _____		Can we contact this person if you are not available? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		Phone (____) ____-_____			

Responsible Party <small>If other than Patient</small>	Responsible Party other than Patient:		Relationship to responsible party: <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Other _____	
	Address if other than Patient's:		Does Responsible party have custodial duties to the Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Responsible Party's Phone Number:		Please explain if the answer is NO:	

Dental Benefit Information <small>(Not Medical)</small>	Policy Holder:	Relationship to Primary Policy Holder:	Policy Holder's DOB:
	Address if different from above:		
	Employer:	Employer Address:	
	Insurance Company:	Policy Number:	Group Number:
	Name of other dependents covered under this plan:		

Additional Dental Benefit Information <small>(Not Medical)</small>	Policy Holder:	Relationship to Secondary Policy Holder:	Policy Holder's DOB:
	Address if different from above:		
	Employer:	Employer Address:	
	Insurance Company:	Policy Number:	Group Number:
	Name of other dependents covered under this plan:		



DOC OF THE BAY
DENTISTRY
Cosmetic & General
John H. Brackett, D.M.D., P.C.

25771 Canal Road • Orange Beach, AL 36561

Phone (251) 981-2273 (CARE)

RELEASE OF RECORDS

I, _____ hereby authorize the release/transfer of current x-rays, progress notes, and applicable medical records to:

(Please indicate doctor)

Please email digital x-rays if able.

John H. Brackett, DMD
25771 Canal Road
Orange Beach, AL 36561
(251) 981-2273 FAX (251) 981-2132
info@docofthebay.com

To/FROM:

Dr. _____

Address: _____

City, St, Zip: _____

Phone: _____

Email: _____

(Print Name)

(Signature)

Date of Patient's Birth: _____