BRATTON DENTAL CO.

Patient Information:

Patient Name: _____ Preferred Name: _____

Birth Date: _____ Male: _____ Female: _____ Married: _____ Single: _____ Minor: Y N

SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Work #: _____ Cell #: _____

E-mail address: _____ Can we text you? YES NO

Employer: _____

Emergency Contact: _____ Phone #: _____

Other family members seen by us: _____

How did you hear of us? _____

If referred by someone, whom may we thank for the referral? _____

Parent/Guardian Information:

Name: _____ Relationship to patient: _____

Birth Date: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Work #: _____ Cell #: _____

Dental Insurance Information (Primary):

Policyholder's Name: _____ Birth Date: _____ SS#: _____

Insurance Company: _____ Group #: _____

Employer: _____ Policyholder's ID#: _____

Patient Relationship to Policyholder: Self _____ Spouse _____ Child _____ Other _____

Dental Insurance Information (Secondary):

Policyholder's Name: _____ Birth Date: _____ SS#: _____

Insurance Company: _____ Group #: _____

Employer: _____ Policyholder's ID#: _____

Patient Relationship to Policyholder: Self _____ Spouse _____ Child _____ Other _____

Bratton Dental Co. Medical History Form 2022(Copy)

Patient Name: Birth Date: Date Created:

Are you currently under a physicians care or have been hospitalized recently? ◯ Yes ◯ No

Are you taking any medications, pills, or drugs? If yes, please list below ◯ Yes ◯ No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No If yes

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 ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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

☐ AIDS/ HIV Positive/ Hepatitis
☐ Diabetes
☐ Anemia
☐ Arthritis/ Rheumatism
☐ Scarlet Fever
☐ Artificial Joint
☐ Asthma
☐ Sinus Trouble
☐ Blood Transfusion
☐ Frequent Headaches
☐ Low Blood Pressure
☐ Glaucoma
☐ Chemotherapy/ Radiation
☐ Osteoporosis
☐ Pain in Jaw Joints
☐ Heart Pacemaker
☐ Tobacco Use
☐ Excessive Bleeding/ Hemophilia
☐ Anaphylaxis/ Allergy
☐ Angina/ Chest pain
☐ Epilepsy or Seizures
☐ Artificial Heart Valve
☐ Excessive Thirst
☐ Fainting Spells/ Dizziness
☐ Blood Disease
☐ Stomach/ Intestinal Disease
☐ Liver Disease
☐ Swelling of Limbs/ Gout
☐ Lung Disease
☐ Mitral Valve Prolapse
☐ Tuberculosis
☐ Tumors or Growths
☐ Ulcers
☐ Alzheimer's Disease
☐ Drug Addiction
☐ High Blood Pressure
☐ High Cholesterol
☐ Shingles
☐ Hypoglycemia
☐ Irregular Heartbeat/ Heart Murmur
☐ Kidney Problems
☐ Breathing Problems/ Easily Winded
☐ Stroke
☐ Cancer
☐ Thyroid Disease
☐ Heart Attack/ Failure
☐ Cold Sores/ Fever Blisters/ Herpes
☐ Congenital Heart Disorder
☐ Psychiatric Care

Have you ever had any serious illness not listed above? ◯ Yes ◯ No

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:

X

Date:_____

BRATTON DENTAL CO.

CONSENT TO DENTAL CARE: By my signature below, I warrant that I am the patient or parent/guardian of the patient. I hereby request and authorize the healthcare providers of Bratton Dental Co, and their professional staff, to perform any dental procedures which in their professional judgment is deemed necessary to properly diagnose and/or treat as needed.

PRIVACY POLICY (HIPAA): I acknowledge that I have r ead the Notice of Privacy Practice for Bratton Dental Co. and a copy will be provided to me upon my request.

FINANCIAL AGREEMENT AND GUARANTEE: I accept full and complete financial responsibility for all dental services rendered to the registered patient(s) and agree to any and all insurance co-payments, deductibles, and co-insurance that may be required under the terms of my dental insurance policies, as well as pay for any dental care that is considered a "non-covered" service under the terms of my dental insurance plan. I further acknowledge, understand and agree, that in the event that I fail to make such payments in accordance with the payment policies of the Practice, or in the event of default of my financial obligation to pay for services rendered, the Practice may terminate the "doctor-patient" relationship with the registered patient(s) in accordance with the Code of Missouri. Furthermore, in the event of my default of my financial obligation, should my account be turned over to an external collection agency for non-payment, I agree to pay any associated collection costs.

I understand that in the event the patient(s) are not covered by a dental insurance plan, I will be required to pay for all services at the time they are rendered.

OFFICE VISITS: are by appointment only. We will try to accommodate walk-ins, however they will not be given priority over patients who have appointments.

LATE POLICY: Patients are asked to arrive 10 minutes before their scheduled appointment time in order to complete the check-in process. Patients arriving more than 20 minutes late will be required to reschedule their appointment to the next available opening consistent with the type of appointment requested.

CANCELLATION POLICY: As a courtesy to both your provider and other patients, we ask that you cancel any scheduled appointment 24 hours in advance so that others may utilize this time. Failure to attend an appointment without prior cancellation is considered a NO SHOW. NO SHOWS may be subject to a missed appointment fee.

PRESENT A VALID INSURANCE CARD AND DRIVERS LICENSE: If you request that we bill your insurance company for your care, you must present a valid insurance card and update our office of any insurance changes. Failure to present a valid card may result in you being responsible for payment in full for that visit. A valid drivers license/photo ID must also be presented.

CHILDREN UNDER 18 MUST HAVE PARENT/GUARDIAN PRESENT: Children under 18 cannot legally consent to their own treatment. Treatment can only be approved by the parent or legal guardian. If you cannot attend their appointment and must send your child(ren) alone, or with an older sibling, grandparent, or nanny, please be aware that they have no legal authority to provide 'consent to treatment' for your child and treatment may be rescheduled for a date in which a parent/guardian can be present.

Signature of Patient/Guarantor: _____ **Date:** _____

Printed Name: _____