Dr. Edy Braun
Periodontics and Implant Dentistry

# NEW PATIENT FORM

Today's Date (y-m-d):

*Please fill out <u>both sides</u> of this form so we can provide you with the safest optimum care. All information will be kept confidential. Dr. Braun will review it with you and answer any questions you may need help with. Thank you.*

## CONTACT INFORMATION

Name: | Birthday (y-m-d): | Title:

Emergency Contact: | Relationship: | Phone:

Family Dentist: | Address: | Phone:

Family Doctor: | Address: | Phone:

Dental Insurance Company: | Subscriber Name:

Subscriber Birthday (y-m-d): | Group/Plan#: | Certificate#:

## HOME

Address:
City: | Postal:
Phone: | Cell:
Email:

## WORK

Occupation:
Employer:
Phone:
Address:

## DENTAL CONCERNS (please check all that apply)

☐ Pain ☐ Bleeding Gums ☐ Loose Teeth ☐ Bad Breath ☐ Shifting Teeth ☐ Nervousness

Other: Please include details here.

## MEDICAL HISTORY (please check all that apply)

| | | | |
|---|---|---|---|
| ☐ Alcohol/Drug Use | ☐ Epilepsy/Seizures | ☐ Immunosuppression | ☐ Poor Healing |
| ☐ Anemia | ☐ Easy Bleeding/Bruising | ☐ Jaundice | ☐ Radiation Treatment |
| ☐ Angina/Chest Pains | ☐ Fainting | ☐ Kidney Disease | ☐ Rheumatic Fever |
| ☐ Arthritis | ☐ Glaucoma | ☐ Liver Disease | ☐ Sinus Problems |
| ☐ Artificial Joint | ☐ Head Injury | ☐ Low Blood Pressure | ☐ Shortness of Breath |
| ☐ Asthma | ☐ Heart Attack | ☐ Lung Disease | ☐ Steroid Therapy |
| ☐ Auto-immune Disease | ☐ Heart Disease | ☐ Lupus | ☐ Stomach Problems |
| ☐ Blood Disorder | ☐ Heart Murmur | ☐ Mental Disorders | ☐ Stroke |
| ☐ Cancer | ☐ Heart Surgery | ☐ Mitral Valve Prolapse | ☐ Thyroid Disease |
| ☐ Chemotherapy | ☐ Hemophilia | ☐ Multiple Sclerosis | ☐ TMJ Disorder |
| ☐ Diabetes | ☐ Hepatitis | ☐ Nervous Disorders | ☐ Tuberculosis |
| ☐ Dizziness/Vertigo | ☐ High Blood Pressure | ☐ Osteoporosis | ☐ Tumors |
| ☐ Emphysema | ☐ HIV (AIDS) | ☐ Pacemaker | ☐ Ulcers |

**Allergies or Reactions:** ☐ Sulpha ☐ Penicillin ☐ Aspirin ☐ Anesthetic ☐ Latex ☐ Codeine

List other allergies or adverse reactions.

**Medications:** List all medications and doses.

**I am currently:** ☐ Pregnant ☐ Breastfeeding ☐ Smoking: If yes, how many per day?

## MEDICAL HISTORY Continued...

Are you being treated for any conditions? ☐ Yes ☐ No Date of last medical exam:

If yes, give details.

Has your general health changed in the last year? ☐ Yes ☐ No

If yes, give details.

Please list diseases in the family, any hospitalizations, and any disease or conditions we did not list above:

If yes, give details.

*To the best of my knowledge, the above information is correct. I promise to inform this office of any changes in my medical status immediately. I consent to examination and treatment as advised. I hereby authorize release of any information related to insurance claims. I understand payment is due when services are rendered by Credit Card, Debit or Cash. Any alternate payment arrangements must be made in advance of treatment.*

Name: Signature: Date:

Sign with digital pen or initial.

## PRIVACY POLICY

Our office complies with federal privacy protection guidelines and requires that patients provide their consent for us to collect, use, disclose or update any personal information. All staff members are trained to protect the privacy of your personal information. Dr. Braun is the designated Privacy Information Officer with whom you may discuss these policies and any concerns you may have. You may view the office privacy code at any time on our website.

By signing below, you consent to the collection of personal and health information about you, or your children (if they are minors and patients of our office), provided that such information is used in the routine operation of our office, such as for the purposes of examining your health, providing treatment, managing appointments, and other such related matters. Such information may be collected through the use of, but not limited to: paper forms, telephone, chair-side discussions and interviews, photographs and x-rays.

You also consent to your information being disclosed: to insurers, payment organization and third parties that may be involved in payment or pre-approval of treatment estimates; to any heath care practitioner involved in your health, such as physicians, dentists, etc; to any potential purchaser and his advisors of this dental office; and for teaching and demonstrating purposes (such as in lectures, the practice web-site, brochures, advertisements) on an anonymous basis.

You are aware that you can withdraw your consent at any time, given reasonable notice in writing. If you should withdraw your consent, you understand that Dr. Braun may be unable to provide you with proper dental care.

Name: Signature: Date:

Sign with digital pen or initial.

## FIRST APPOINTMENT CHECKLIST (please check that you completed all these items)

- ☐ This form completely filled, signed, dated (new patient info, medical history and privacy policy)
- ☐ Referral Form if provided by your dental office
- ☐ I am bringing any X-rays that I may have
- ☐ COVID Screening form (if still applicable)