Dr. Edy Braun

Periodontics and Implant Dentistry

NEW PATIENT FORM (Part 1)

Today's Date: _____

Please fill out both sides 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: _____

Date of birth: _____ Title: Mr Mrs Ms Dr

Home address: _____

City: _____ Postal: _____

Home phone: _____ Cell: _____

Email: _____

Occupation: _____

Employer: _____ Phone: _____

Work address: _____

IN CASE OF EMERGENCY

Person to Notify: _____

Relationship: _____

Day-Time Phone:

DOCTOR INFORMATION

Family Doctor: _____

Address: _____

Phone:

DENTAL INSURANCE INFORMATION

Ins. Company: _____

Subscriber Name: _____

Subscriber D.O.B.: _____

Group/Plan#: _____

Certificate#:

DENTAL CONCERNS (please check all that apply)

q Tooth Pain q Bleeding Gums q Loose Teeth
q Bad Breath q Shifting Teeth q Nervousness
q Other:

MEDICAL INFORMATION

1. Are you being treated for any medical conditions? q YES q NO q NOT SURE
   Please explain: _____

2. Date of last medical exam: _____

3. Has your general health changed in the last year? q YES q NO q NOT SURE
   Please explain: _____

4. Do you smoke? Amount: _____

5. List all medications you take: _____ _____ _____ _____

6. Allergies and adverse reactions:
   q Penicillin q Sulpha q Aspirin
   q Anesthetic q Latex q Codeine
   q Other:

7. Breastfeeding/pregnant? q YES q NO

8. Diseases in the family:

9. Hospitalizations:

PLEASE CHECK ALL THAT APPLY

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

Do you have any disease, problem or condition not listed above? _____

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 by Dr. Braun. 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.

Patient/Parent/Guardian Signature: _____ Dr. Braun: _____

FLIP OVER è

NEW PATIENT FORM **(Part 2)**

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.

Print Name	Signature	Date: (dd/mm/yy)

FIRST APPOINTMENT CHECKLIST **(Part 3)**

Please bring all these items and make sure they have been completed:

- q **New Patient Form** on reverse of this page (completed & signed)
- q **Privacy Policy** above (signed)
- q **Referral Form** if provided by your dental office
- q I am bringing any **X-rays** that I may have
- q I have **confirmed** my scheduled appointment for…

Date: _____ Time: _____

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