WELCOME to the Office of Dr. Robert M. Browne. We're glad you're here!

PATIENT INFORMATION

Purpose of today's visit_____

Who may we thank for referring you to us?_____

PATIENT NAME: Dr. Mr. Mrs. Ms.

_____

(last) (first) (middle)

What would you like to be called in our office?_____

Home Address_____

City_____State____Zip_____

Birth date___/___/___Soc. Sec. No._____

Home #_____Cell#_____

Work #_____Email_____

Children (names and ages)_____

_____

Employer_____

Occupation_____

Employer Address_____

Dental Insurance_____

Group #_____

Subscriber #_____

SPOUSE/PARENT NAME_____

Home Address_____

City_____State____Zip_____

Birth date___/___/___Soc. Sec. No._____

Home #_____Cell#_____

Work #_____Email_____

Employer_____

Occupation_____

Employer Address_____

Dental Insurance_____

Group #_____

Subscriber #_____

I hereby authorize payment directly to Robert M. Browne, DDS of the group insurance benefits otherwise payable. I accept this attending dentist's statement and authorize the release of information relating thereto. I certify the truth of all personal information contained above.. I understand that payment is my obligation regardless of insurance or any other third-party involvement. Any unpaid balance after 90 days will be charged with 1.5% interest per month. If account is sent to a collection agency, the patient/guardian will be responsible for any collection fees or court costs.

_____

Patient (parent/guardian) signature Date

MEDICAL INFORMATION

Name and address of physician_____

Person to be contacted in case of emergency_____Phone #_____

How often do you see your physician?_____

Date of last physical examination_____/_____Did it include blood test_____EKG_____

List all drugs and medications that you are taking currently_____

_____

_____

Please describe your current physical health: excellent very good fairly good fair

Are you under the care of a physician? If yes, please explain_____

Have you ever had a serious illness or accident? If yes, please explain_____

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR PRESENTLY HAVE

Allergies
Anemia
Angina
Arthritis
Artificial Heart Valve
Artificial Hip/Knee
Asthma/Hay Fever
Blood Transfusion
Cancer
Cold Sores
Congenital Heart Lesion
Diabetes
Drug/Alcohol Addiction
Emphysema
Epilepsy
Fainting Spells
Fever Blisters
Glaucoma
Heart Attack
Heart Murmur
Heart Surgery
Hemophilia
Hepatitis A
Hepatitis B
Hepatitis C
High Blood Pressure
HIV/AIDS
Kidney Disease
Liver Disease
Low Blood Pressure
Mitral Valve Prolapse
Pacemaker
Pain in Jaw Joints
Psychological Counseling
Rheumatic Fever
Scarlet Fever
Sickle Cell Disease
Sinus Trouble
Stroke
Ulcers
Unusual Bruising/Bleeding
Venereal Disease
Yellow Jaundice

Women Are You:

Pregnant
Taking Birth Control
Taking Hormones
Nursing

Are You Allergic To: Codeine Darvocet Erythromycin Ibuprofen Keflex Latex Penicillin Tetracycline Tylenol Vicodin Other_____

Have you ever been told by a physician that you should be pre-medicated with an antibiotic before a dental appointment? Yes_____ No_____ If yes, name and dosage of antibiotic_____

DENTAL HISTORY

Name of your former dentist_____Reason for changing_____

Are you aware of a dental problem? Please explain_____

When was your last visit?_____

When was your last set of full mouth x-rays?_____

Are you happy with the appearance of your teeth? Please explain_____

Describe any problems with past dental care_____

Would you like to discuss straighter teeth? Yes_____ No_____

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT

Bite Feels Off
Biteguard
Bleeding Gums
Braces
Clenching Teeth
Fever Blisters
Food Collects
Grinding Teeth
Gum Disease
Locked Jaw
Mouth Sores
Noise in Jaw Joint
Smoker
Teeth Sensitive to Hot
Teeth Sensitive to Cold
Trouble Chewing/Speaking
Unpleasant Taste/Odor
Wears Partials/Dentures
Wisdom Teeth Removed

I certify the truth of all medical information above_____

Patient (parent/guardian) signature

PAYMENT OPTIONS

We are happy to offer several ways to achieve the healthy smile of your dreams without ever letting money stand in your way. It can be as simple as finding the balance between your needs and the right payment option for you. That is why we always inform you of cost in advance of proceeding with your recommended and desired dental care. We'll help you design a plan for the timing, financing, and completion of treatment that is the best choice for you.

Dental Insurance: Our administrative staff will assist you evaluating and maximizing your dental insurance benefits. We encourage you to familiarize yourself with and understand how your policy works. Most insurance plans offer a limited benefit in a contracted year. Patients will typically have a deductible and/or a co-pay for services performed. As a courtesy to you we will file your insurance claims.

Accepted Methods of Payment: Visa, MasterCard, and Discover are accepted at our office for your convenience. Cash and checks are welcomed forms of payment also.

Care Credit: Care Credit is a third-party healthcare financing company. Applying is quick and easy in our office, online, or by telephone. Once your application is submitted you will receive an instant response regarding acceptance and you may use the approved credit immediately. Dr. Browne offers 6 month, zero interest financing options which allows flexibility and convenience managing your dental care budget.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You may refuse to sign this acknowledgement)

I,_____, have received a copy of this office's Notice of
(please print name)

Privacy Practices.

_____

(signature) (date)

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Refusal to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (please specify)

_____

_____