BD BRAMMER DENTAL BROOKHAVEN

JEFFREY BRAMMER DDS MS

WWW.BRAMMERDENTAL.COM
(405)701-2922

COSMETICS • IMPLANTS • BRACES • FAMILY DENTISTRY

3700 W ROBINSON, STE 102
NORMAN, OK 73072

PATIENT INFORMATION

Date: ☐NEW PATIENT ☐UPDATE

Patient:

LAST FIRST MI PREFERRED TITLE

__MALE __FEMALE __CHILD* __STUDENT** __SINGLE __MARRIED __DIVORCED __WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:

PARENT/GUARDIAN NAME(S)

**IF STUDENT, PLEASE COMPLETE: __FULL-TIME __PART-TIME

SCHOOL/LOCATION

Patient Date of Birth: Patient SSN:

Address:

ADDRESS LINE 1

ADDRESS LINE 2

CITY T ZIP CODE

HOME:
CELL:
OTHER:

E-Mail:

Referral? __Yes __ No Referred by:

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

NAME RELATIONSHIP

Tel:

EMPLOYMENT INFORMATION

Employer: Occupation:

Address:

ADDRESS LINE 1

ADDRESS LINE 2

CITY ST ZIP CODE

WORK: X
DIRECT:
OTHER:

E-Mail:

INSURANCE INFORMATION

Subscriber:

LAST FIRST MI PREFERRED TITLE

Subscriber Date of Birth: Subscriber SSN:

Subscriber Employer:

Patient Relationship to Subscriber: __SELF __SPOUSE __CHILD __OTHER

PRIMARY INSURANCE CARRIER:

Group/Policy No.: ID No.:

Address:

CITY ST ZIP CODE

TEL:
TOLL-FREE:
FAX:

SECONDARY INSURANCE CARRIER:

Group/Policy No.: ID No.:

Address:

CITY ST ZIP CODE

TEL:
TOLL-FREE:
FAX:

BD BRAMMER DENTAL BROOKHAVEN

JEFFREY BRAMMER DDS MS

WWW.BRAMMERDENTAL.COM
(405)701-2922

COSMETICS • IMPLANTS • BRACES • FAMILY DENTISTRY

3700 W ROBINSON, STE 102
NORMAN, OK 73072

DENTAL HISTORY

ORAL HEALTH: __EXCELLENT __GOOD __FAIR __POOR

Date of Last Dental Visit: _____ Treatment Type: _____

Y N Are you currently having dental discomfort? If yes, explain: _____
Y N Any unhappy/unpleasant dental experiences? If yes, explain: _____
Y N Any injuries to mouth/teeth/head? If yes, explain: _____
Y N Any missing teeth other than wisdom teeth?
Y N Have missing teeth been replaced?
Y N Orthodontic appliances (braces) now or in the past?
Y N Gums bleed when brushing or flossing?
Y N Concerned about gum disease? History of gum disease?
Y N Do you dislike the appearance of your teeth?
Y N Does it hurt to bite or chew?
Y N Do you clench or grind your teeth? If so, do you wear a night guard or splint?
Y N Do you want to become a regular continuing care patient in our practice?
Y N Do you want your mouth properly restored and pain free?
Y N Does any type of dental treatment make you nervous? If yes, please explain below:

_____

The most important concerns regarding my dental treatment are:

_____

What factors are most important for your satisfaction with our office?

_____

Any additional concerns/comments?

_____

CHILD/MINOR PATIENTS: PLEASE ANSWER THE FOLLOWING QUESTIONS:

Y N Any mouth habits? (thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc.)

_____

Y N Any unusual speech habits? If yes, explain: _____
Y N Any lost teeth? If yes, list: _____
Y N Does the patient receive assistance with brushing and flossing? If yes, how often?

_____

PRIMARY PHYSICIAN INFORMATION

Physician: _____ Telephone: _____

Clinic/Facility: _____

MEDICAL HISTORY

GENERAL HEALTH: __EXCELLENT __GOOD __FAIR __POOR

Y N Under a physician's care now?
Y N Any hospitalization in the past 5 years? _____
Y N Any serious illnesses/surgeries? _____
Y N Use tobacco in any form? If Yes, Type: _____
Y N Is pre-medication required before dental visits due to heart condition or artificial joint?
Y N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS: __Y__N Currently nursing? __Y__N Currently pregnant? Due Date: _____

BRAMMER DENTAL
BROOKHAVEN

JEFFREY BRAMMER DDS MS

WWW.BRAMMERDENTAL.COM
(405)701-2922

COSMETICS • IMPLANTS • BRACES • FAMILY DENTISTRY

3700 W ROBINSON, STE 102
NORMAN, OK 73072

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? __Y__N
If yes, please describe:

Is there anything important about your medical condition we have not asked? __Y__N If yes, please describe:

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): __NONE

__ACID REFLUX
__ADHD
__AIDS/HIV
__ANEMIA
__ANOREXIA
__ANXIETY
__ARTIFICIAL HEART VALVE
__ARTIFICIAL JOINTS
__ARTHRITIS
__ASTHMA
__AUTISM/ASPERGER'S
__BLEEDING DISORDER
__BULIMIA
__CANCER/MALIGNANCY
__CEREBRAL PALSY
__CHEMICAL DEPENDENCY
__CHICKEN POX
__CONVULSIONS
__DEPRESSION
__DIABETES
__DIZZINESS/FAINTING
__EPILEPSY/SEIZURES
__FREQUENT EAR INFECTIONS
__ FREQUENT HEADACHES
__HEARING PROBLEMS
__HEART ATTACK
__HEART DISEASE
__HEART MURMUR
__HEPATITIS
__HIGH BLOOD PRESSURE
__KIDNEY DISEASE
__LIVER PROBLEMS
__MITRAL VALVE PROLAPSE
__MONONUCLEOSIS
__PACEMAKER
__OTHER – PLEASE LIST:
__PSYCHIATRIC TREATMENT
__RADIATION/CHEMO
__RESPIRATORY DISEASE
__RHEUMATIC FEVER
__SINUS PROBLEMS
__STROKE
__THYROID CONDITION
__TUBERCULOSIS
__ULCERS
__VENEREAL DISEASE

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY): __NONE

__ASPIRIN
__ANESTHETIC – LOCAL
__BARBITURATES
__CODEINE
__DAIRY
__LATEX
__LACTOSE INTOLERANCE
__METAL SENSITIVITY
__NITROUS OXIDE SEDATION
__SLEEPING PILLS
__SULFA DRUGS
__PENICILLIN/OTHER ANTIBIOTICS
__OTHER – PLEASE LIST:

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): __NONE

__ANTIBIOTICS/SULFA DRUGS
__BLOOD THINNERS
__INSULIN
__OTHER DIABETIC MEDICATIONS
__ANTIHISTAMINES/ALLERGY
__CANCER/CHEMO MEDICATIONS
__NITROGLYCERIN
__RECREATIONAL DRUGS
__DAILY ASPIRIN
__CORTISONE/STEROIDS
__ORAL CONTRACEPTIVES
__THYROID MEDICATIONS
__BLOOD PRESSURE MEDICATIONS
__HEART MEDICATION/DIGITALIS
__OSTEOPOROSIS MEDICATIONS
__TRANQUILIZERS
__OTHER (PLEASE LIST BELOW)

DRUG NAME	DOSAGE	REASON PRESCRIBED

BD BRAMMER DENTAL BROOKHAVEN

JEFFREY BRAMMER DDS MS

COSMETICS • IMPLANTS • BRACES • FAMILY DENTISTRY

WWW.BRAMMERDENTAL.COM
(405)701-2922
3700 W ROBINSON, STE 102
NORMAN, OK 73072

Financial Guidelines

We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.

Insurance

We are in network with many insurance providers and accept all insurances (no HMO insurances accepted). If we are not an in network provider, review your plan details, as in many cases insurance reimbursement is very similar.

- **No estimate is a guarantee of payment.** Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference.
- **Minors must be accompanied by a parent or legal guardian**. If the parents are separated or divorced, the person accompanying the minor will be responsible for copayment at the time of service.

Payments

- **Patient portion or patient co-pay is due at the time services are rendered** - unless prior financial arrangements have been made.
- **Payment Information:**
  - All major credit cards are accepted (Visa, MasterCard, Discover)
  - 5% Discount for our uninsured cash/check paying patients if full treatment plan payment made
  - Various financing options with CareCredit®, CitiHealth® and Lending Club®
- **Balances left over 90 days will incur an 18% or $10 minimum monthly finance charge.** We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Short Cancelled/ Missed Appointments

- **Please give 48 hours notice** if you are unable to keep your reserved time. Unless an emergency occurs, we expect to run on time for your appointments, and we appreciate the same courtesy from you.
- **Short canceled or missed appointments** may be charged up to one dollar per minute of time allotted for your appointment.

By signing below I acknowledge I have read and understand the guidelines above.

Signature: Date:

BD BRAMMER DENTAL BROOKHAVEN

JEFFREY BRAMMER DDS MS

COSMETICS • IMPLANTS • BRACES • FAMILY DENTISTRY

WWW.BRAMMERDENTAL.COM
(405)701-2922
3700 W ROBINSON, STE 102
NORMAN, OK 73072

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Updated 2016

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that my health information is necessary for and agree that this information may be used by personnel to whom it is pertinent, in order to complete my treatment, submit claims to insurance and any other procedures necessary which may warrant use of my health information.

I understand that my health information will be held in confidence and only used by those who need it in order to complete my health services.

Signature: **Date:**

RELATIONSHIP TO PATIENT: __ADULT PATIENT __PARENT __GUARDIAN __OTHER

Please list any dependent children under the age of 18 also covered by this acknowledgement:

I give permission for the following communications to be used by Brammer Dental **(please check all that apply)** :

___ Cell phone: __Text Message reminders permitted
___ Home phone ___ Work ___ E-Mail:

___ I am granting permission for Brammer Dental to disclose their identity to anyone who may answer my home, work or cell phone.

___ I am granting permission for Brammer Dental to use pictures of myself or dependents on Brammer Dental social media sites, marketing or brammerdental.com.

I would like to give permission for the following person(s) to have access to personal information including but not limited to appointments, treatment, and billing of myself and any dependent children listed above:

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

___ The patient refused to sign
___ Communication barriers
___ Emergency situation
___ Other – please list:

BD BRAMMER DENTAL BROOKHAVEN

JEFFREY BRAMMER DDS MS

COSMETICS • IMPLANTS • BRACES • FAMILY DENTISTRY

WWW.BRAMMERDENTAL.COM
(405)701-2922
3700 W ROBINSON, STE 102
NORMAN, OK 73072

PATIENT CONSENT- PAYMENT AUTHORIZATION – SIGNATURE ON FILE

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status of if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

I hereby authorize payment directly to Brammer Dental of the dental benefits otherwise payable to me.

I hereby authorize Brammer Dental to release any information concerning my health or dental care, advice, treatment or supplies provided. This information is to be used in administering dental claims and/or discussing treatment options with other dental professionals.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Signature: Date: