PATIENT INFORMATION

Name:____
Last First Middle Initial Nickname

D.O.B.________________ Social Security#:________________ Marital Status:__________ Sex: Male or Female

Address:____

City:____ State:_________________ Zip Code:_______________

Employment Status:__________________________________ Employer:___________________________________

Employer Address:____
Street City, State Zip

Whom may we thank for referring you?____

PHONE NUMBERS

Home: (_____)________________ Work:(_____)________________Ext_____ Cell(_____)________________

In Case of Emergency: Name:____ Phone:(_____)________________

DENTAL INSURANCE INFORMATION

Insurance Company:___________________________________Group Number:____________________________

Subscriber Name:_____________________________________Relationship to Patient:_____________________

Subscriber S.S.# or ID#:________________________________Subscriber D.O.B.:_________________________

Subscriber's Employer:_________________________________Employment Status:________________________

Employee Address:____
Street City, State Zip

Assignment and Release

I certify that I, and/or my dependent(s) have insurance coverage with___________________________________

And assign directly to Drs. Howard & Joy Brauer all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. Furthermore, I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

____ X____
Printed Name of Patient or Guardian Signature of Patient or Guardian

______________________ ______________________
Relationship to Patient Date of Signature

Dental History

Reason for today's visit:___________________________How often do you brush?__________How often do you floss?__________

Date of last exam:____________Date of last X-rays:____________Name of Former Dentist:________________________________

Place a mark on "yes" or "no" to indicate if you currently have or have had any of the following:

☐Yes ☐No	Bad Breath	☐Yes ☐No	Food between teeth	☐Yes ☐No	Orthodontic Treatment
☐Yes ☐No	Bleeding Gums	☐Yes ☐No	Blisters on lips / mouth	☐Yes ☐No	Pain around ear
☐Yes ☐No	Chew on one side	☐Yes ☐No	Mouth Pain (brushing)	☐Yes ☐No	Periodontal Treatment
☐Yes ☐No	Smoking	☐Yes ☐No	Clicking Jaw	☐Yes ☐No	Sensitivity to cold
☐Yes ☐No	Dry mouth	☐Yes ☐No	Fingernail Biting	☐Yes ☐No	Sensitivity to heat
☐Yes ☐No	Grinding teeth	☐Yes ☐No	Swollen / Tender Gums	☐Yes ☐No	Sensitivity to Sweets
☐Yes ☐No	Jaw Pain / Tiredness	☐Yes ☐No	Lip / Cheek Biting	☐Yes ☐No	Sensitivity when biting
☐Yes ☐No	Mouth breathing	☐Yes ☐No	Burning sensation on tongue	☐Yes ☐No	Loose teeth or Broken fillings

Medical History

Physician's Name:__________________________________ Date of your last visit:_______________________________

☐Yes ☐No Are you currently taking any medications? List:____

☐Yes ☐No Are you allergic to any medications? List:____

☐Yes ☐No Do you take aspirin? If yes, how often?_________

☐Yes ☐No Are you allergic to latex?

☐Yes ☐No Have you ever taken any of the group of drugs collectively referred to as "fen-Phen?" These combinations of lonimin, Adipex, Fastin (brand name for phentermine), Pondimin (fenfluramine) and Redux (desfenfluramine)?

Woman Only Are you Pregnant? ☐Yes ☐No Are you nursing? ☐Yes ☐No Do you take birth control pills? ☐Yes ☐No
Due Date:______________

Place a mark on "yes" or "no" to indicate if you currently have or have had any of the following:

☐Yes ☐No	AIDS/HIV	☐Yes ☐No	Epilepsy	☐Yes ☐No	Radiation Treatment
☐Yes ☐No	Anemia	☐Yes ☐No	Fainting or Dizziness	☐Yes ☐No	Respiratory Disease
☐Yes ☐No	Arthritis, Rheumatism	☐Yes ☐No	Glaucoma	☐Yes ☐No	Rheumatic Fever
☐Yes ☐No	Artificial Heart Valve	☐Yes ☐No	Headaches	☐Yes ☐No	Scarlet Fever
☐Yes ☐No	Artificial Joints	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Shortness of Breath
☐Yes ☐No	Asthma	☐Yes ☐No	Heart Problems	☐Yes ☐No	Sinus Trouble
☐Yes ☐No	Back Problems	☐Yes ☐No	Hepatitis, Type____	☐Yes ☐No	Skin Rash
☐Yes ☐No	Excessive Bleeding	☐Yes ☐No	Oral Herpes	☐Yes ☐No	Special Diet
☐Yes ☐No	Blood Disease	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Stroke
☐Yes ☐No	Cancer	☐Yes ☐No	Jaundice	☐Yes ☐No	Swollen Feet / Ankles
☐Yes ☐No	Chemical Dependency	☐Yes ☐No	Jaw Pain	☐Yes ☐No	Swollen Neck Glands
☐Yes ☐No	Chemotherapy	☐Yes ☐No	Kidney Disease	☐Yes ☐No	Thyroid Problems
☐Yes ☐No	Circulatory Problems	☐Yes ☐No	Liver Disease	☐Yes ☐No	Tonsillitis
☐Yes ☐No	Congenital Heart Lesions	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No	Tuberculosis
☐Yes ☐No	Cortisone Treatments	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No	Tumor on Head / Neck
☐Yes ☐No	Cough (Persistent/Bloody)	☐Yes ☐No	Nervous Disorder	☐Yes ☐No	Ulcer
☐Yes ☐No	Diabetes	☐Yes ☐No	Pacemaker	☐Yes ☐No	Weight Loss (sudden)
☐Yes ☐No	Emphysema	☐Yes ☐No	Psychiatric Care		

I certify that the above statements about my medical history are accurate. I authorize and give consent for my dentist to perform dental services agreed upon; including the use of local anesthesia as necessary for treatment.

X____________________________________/_____________ ______________________________________

Signature of Patient/Guardian Date Signature of Dentist

Because we are committed to providing the best in dental care, our office has chosen not to use amalgam (silver) fillings, in most circumstances. Amalgam fillings require the destruction of larger amounts of healthy tooth than necessary. This, in turn, can lead to cracking of the tooth and the possibility of needing a crown.

Instead, we choose to use resin (tooth-colored) fillings. In addition to being more aesthetically pleasing, resins (also called composites) are bonded to the tooth. This allows the dentist to remove only unhealthy tooth structure.

Unfortunately, most insurance companies will only reimburse for amalgam fillings, leaving the patient to pay the difference. Most of the time this amount is very minimal, and well worth the additional cost.

I have read and I understand the above policy. If my insurance company does not Reimburse for resin fillings, I agree to compensate the dentist for the difference.

Signature____Date_________________

Print Name____

Drs. Howard & Joy Brauer
3336 E. Chandler Heights Rd., Suite 119 • Gilbert, AZ 85298

Financial Policy

As a professional courtesy to our patients, we make every effort to inform you about the cost of your dental care prior to your treatment. Despite our best efforts, we cannot always anticipate every cost, or how much your insurance plan will reimburse. In order to diminish unforeseen expenses, we ask that you, too, become informed about your insurance coverage. Together, we can achieve better results.

Payment is expected on the day that dental services are rendered. If you have dental insurance, we will be happy to submit your claim on your behalf. If your coverage can be verified, then we will collect any deductibles, co-payments, or co-insurance on the day of services and bill your insurance company for the remaining balance. In the event that your coverage cannot be verified prior to your treatment, we will collect payment in full at the time of your service, and provide you with the forms to submit to your insurance company for reimbursement. *Please note that reimbursement from your insurance company is not guaranteed; any unpaid claims are the patient's / guarantor's responsibility.*

Cancellation Policy

We understand that occasionally unplanned events require you to break an appointment with us. When this happens please extend to us the courtesy of at least 24 hours advance notice. We will be happy to reschedule your appointment to a more convenient time. Failure to notify the office could result in a $45 fee per hour of scheduled time.

I have read and accept the terms of the financial and cancellation policies.

Signature________________________________ Date_____________________

*For your convenience, we accept payment by cash, debit cards, personal checks, MasterCard, Visa, Discover, American Express & Care Credit.

Drs. Howie & Joy Brauer

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse To Sign This Acknowledgement

I,____, have reviewed a copy of this office's Notice of Privacy Practices.

____
Please Print Name

X____
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:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify

____

____

____

Joy Brauer DDS and Howard Brauer DDS

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/01/2003), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we crated or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notices please contact us using the information listed at the end of this Notice.

USES AND DISCLOSERS OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use or disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose y our health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or discloser your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death.
If you are present, then prior to use or disclosure of you health information, we will provide you with any opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information base on determination using our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required By Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate the authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement official having custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We must use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the rights to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending a letter to the address at the end of this Notice. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclose your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handles under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this notice on our Web site or by electronic mail (e-mail), you are entitled to receive this notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health Services. We will provide you with the address to file your complaint with the U.S. Department of Health Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health Services

Contact Officer: Joy Brauer DDS * Telephone (480) 279-4790

E-Mail: joybrauer@hotmail.com

Address: 3336 E. Chandler Heights Road, Suite 119 • Gilbert, AZ 85297