New Patient Pre-Appointment Check-List

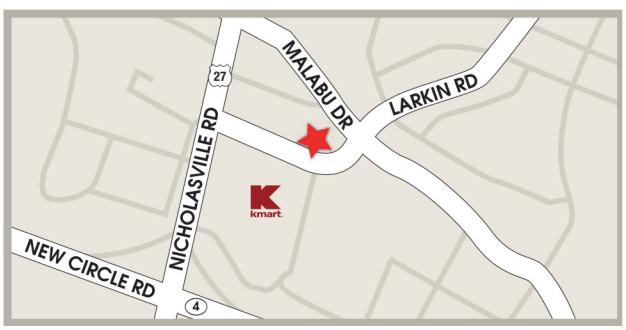
Welcome to our practice. We want to make sure your first visit to our office is an exceptional one. To help us meet your expectations please use this check-list to make sure we have all of the information we will need for your visit.

- ☐ **Contact your previous dentist and ask them to send your records to: brewerdental@gmail.com or the address below.**
- ☐ **Complete new patient forms before you arrive and bring them with you to your appointment, or fill the forms out online electronically at BrewerFamilyDental.com**
- ☐ **Arrive 10 minutes before your scheduled time to allow us to review your paperwork before your appointment**
- ☐ **If you have insurance, please bring your insurance card (if one was issued)**
- ☐ **Bring your driver's license or other government issued photo ID**
- ☐ **If you are a dependent on an insurance plan please have:**
  - **Insured's Name, Address & Phone Number**
  - **Insured's Plan, Member ID# or SSN**
  - **Insured's Date of Birth**
  - **Insurance Group Number**
  - **Insured's Employer**
- ☐ **Have a list of all medications you are currently taking**
- ☐ **Take any pre-medications required by your physician**

We look forward to meeting you!

Kevin S. Brewer, DMD and Team

Brewer Family Dental
2505 Larkin Rd #102
Lexington, KY 40503
859-277-7721
brewerdental@gmail.com



About You

Patient Name _____

What do you prefer to be called _____

Address _____

City _____ ST ___ Zip _____

Home Phone _____

Cell Phone _____

Work Phone _____

Employer _____

Occupation _____

If Student, Name of School _____

Email _____

SSN _____

Birthdate _____ □ Male □ Female

□ Minor □ Single □ Married □ Divorced □ Widowed

If Married, Name of Spouse _____

Please check all the ways you heard about our office

□ Friend/Family □ Internet □ Social Media

□ Insurance □ Print Ad □ Radio

□ Other:

If a friend or family member referred you, we would like to thank them. To whom may we send our thanks?

_____

Billing Info

□ **Same As Above**

Person Responsible for this Account:

_____

Phone _____

Email _____

Address _____

City _____ ST ___ Zip _____

Relationship to Patient _____

Employer _____

I hereby authorize assignment of my insurance benefits directly to the provider for services rendered. I fully understand that I am responsible for all charges to my account regardless of the decision of my insurance company to pay or deny benefits for any reason. I also understand that a fee for missed appointments with less than 2 business days notice will be assessed to my account. No appointments will be made until this fee is paid.

_____ Date _____

Signature of Patient/Parent if Under 18/Guardian

Brewer Family Dental
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Brewer FAMILY DENTAL

Dental Insurance Info

Primary Insurance:

Insured's Name _____

Relationship to Patient _____

Birthdate _____ □ Male □ Female

Employer _____

Work Phone _____

Other Dependents Covered on this Plan:

_____

Insurance Carrier _____

Ins. Co. Address _____

City _____ ST ___ Zip _____

Policy/ID # _____

SSN # (if no policy #) _____

Group # _____

Deductible $ _____ Annual Maximum $ _____

Secondary Insurance:

Insured's Name _____

Relationship to Patient _____

Birthdate _____ □ Male □ Female

Employer _____

Work Phone _____

Other Dependents Covered on this Plan:

_____

Insurance Carrier _____

Ins. Co. Address _____

City _____ ST ___ Zip _____

Policy/ID # _____

SSN # (if no policy #) _____

Group # _____

Deductible $ _____ Annual Maximum $ _____

In Case of Emergency

Whom should we contact? _____

Relation _____

Home Phone _____

Cell Phone _____

Work Phone _____

List people we can discuss your information with:

_____

Medications

Are you allergic or have you reacted adversely to any of the following?

□ Penicillin □ Nitrous Oxide □ Latex
□ Tetracycline □ Local Anesthetic □ Aspirin
□ Other _____

Have you ever taken any of the following?

□ Actonel □ Fosamax □ Herbal Supplements
□ Aredia □ Reclast □ Boniva □ Zometa
□ Diet Pills □ Bone Medication

What medication are you currently taking, including herbal supplements? _____

_____

Medical History

Currently under the care of a physician? □ Yes □ No
Have you ever been hospitalized? □ Yes □ No
Reason _____
Women, are you pregnant? □ Yes □ No
Are you nursing ? □ Yes □ No
Taking birth control pills? □ Yes □ No
Have you ever, or do you now use controlled substances? □ Yes □ No
Are you on a special diet? □ Yes □ No

Please check if you have, or have had any of the following medical conditions:

□ Heart Problems
□ Heart Murmur
□ High/Low Blood Pressure
□ Emphysema
□ Arthritis, Rheumatism
□ Pacemaker
□ Cancer of any Kind
□ Radiation Treatment
□ Diabetes
□ Asthma
□ Anemia
□ Fainting/Dizziness
□ Respiratory Disease
□ Hemophilia
□ Hepatitis
□ Kidney Problems
□ Liver Disease
□ Rheumatic Fever
□ Scarlet Fever
□ Multiple Sclerosis
□ Stomach/Intestinal
□ Tuberculosis
□ Venereal Disease
□ Glaucoma
□ Back Problems
□ Mitral Valve Prolapse
□ Artificial Heart Valve
□ Chemical Dependency
□ Stroke
□ Chest Pain
□ Circulatory Problems
□ Chemotherapy
□ Artificial Joints
□ Shortness of Breath
□ Blood Disease
□ Epilepsy or Seizures
□ Excessive Thirst
□ Frequent Cough
□ Herpes
□ HIV/Aids
□ Hypoglycemia
□ Headaches
□ Jaw Pain
□ Sinus Trouble
□ Muscular Dystrophy
□ Thyroid Disease
□ Ulcers
□ Seasonal Allergies
□ Human Papillomavirus (HPV)
□ Skin Rash
□ Swelling of Feet or Ankles
□ Blood Transfusion
□ Serious Illness or Operation
□ Bone Medications

Other: _____

_____

Dental History

When was your last dental exam? _____
How often do you have your teeth cleaned? _____
Are you experiencing dental pain now? □ Yes □ No
If so, where? □ Upper Left □ Upper Front □ Upper Right
□ Lower Left □ Lower Front □ Lower Right
Is the pain associated with?
□ Biting □ Sweets □ Cold □ Heat □ Air
Are you taking any medications for this pain? □ Yes □ No
Are you apprehensive about dental treatment? □ Yes □ No
Does food become lodged between teeth? □ Yes □ No
Do you have difficulty chewing your food? □ Yes □ No
Do you avoid brushing, flossing, or chewing part of your mouth due to pain? □ Yes □ No
Does your breath concern you? □ Yes □ No
Have you ever been diagnosed with periodontitis or periodontal disease? □ Yes □ No
Have you ever noticed slow healing sores in your mouth? □ Yes □ No
Do you smoke or chew tobacco? □ Yes □ No
Do you brush your teeth at least twice a day? □ Yes □ No
Do you floss at least once a day? □ Yes □ No
Do you clench or grind your teeth? □ Yes □ No
Does your jaw hurt when you chew or open it wide to take a bite? □ Yes □ No
Do you know of any reason to take a pre-medication prior to medical or dental care? □ Yes □ No
What would you change about your smile?

_____

What did you like about your previous dentist?

_____

What did you dislike about your previous dentist?

_____

Are you interested in Invisalign braces? □ Yes □ No
Are you interested in whitening your teeth? □ Yes □ No
Previous Dentist _____
Telephone # _____
Medical Doctor _____
Telephone # _____

I understand that the information I have provided on these forms is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be necessary, you have my permission to request that information from the respective health care provider and for them to release to you. I will notify the doctor of any change in my health or medication.

_____ Date _____
Signature of Patient/Parent if Under 18/Guardian

_____
Printed Name

Financial Policies and Acknowledgements

Brewer Family Dental
2505 Larkin Rd #102
Lexington, KY 40503
859-277-7721
brewerdental@gmail.com

We believe that all patients deserve to know, up front, our financial policies. Below are our policies relating to your dental care.

Payments at time of service:

At the time of service, your estimated co-payment is due. For procedures with multiple appointments, at least fifty percent of your estimated portion is due at the first appointment and the balance is due by the beginning of the final appointment.

Dental Insurance:

As a courtesy we will file your insurance claim for you. We offer this service to you as a courtesy only and it is not meant to be a substitute for payment. We will attempt to collect from your insurance carrier their portion of the charges for your visit. We can not guarantee that they will pay any amount for your treatment. Each plan has different exclusions and limitations and those exclusions and limitations change over time. Our office recommends dental treatment based on medical necessity and not on whether your insurance company will cover a procedure. It is your responsibility to know your dental coverage. It is your responsibility to pay any amount not covered by your insurance company regardless of the reason. We will instruct your insurance carrier to send all payments directly to our office for reimbursement.

Pre-Determination of Insurance Benefits:

Pre-determinations may be filed upon request to your insurance company to reduce but not eliminate risk of error in estimating your co-payment. A pre-determination is not a guarantee of coverage and can take 3-4 weeks to process.

Third-Party Financing:

Brewer Family Dental offers financing options through various third-party lenders. Arrangements for these options must be made in advance of your appointment.

Interest Charges:

Patient balances sixty (60) days and older will be assessed an interest charge of 1.5% per month, or 18% per annum with a minimum charge of $5.00 per billing period.

Collection Charge and Returned Checks:

Any account sent to an outside collection agency will be assessed a $50 collection fee. Any check returned for any reason by your bank will be assessed a $35 fee.

Missed/Cancelled Appointment Charge:

Any appointment not cancelled within 2 business days of the appointment will be subject to a charge of $50.00. No further appointments will be made until the fee is paid.

I have read, understood and agreed to all of the above Financial Policies of Brewer Family Dental and Kevin S. Brewer DMD. I understand that treatment can not begin until this form is signed and agreed to.

_____ _____

Signature of Patient/Parent if Under 18/Guardian Date

_____

Printed Name

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice of Privacy Practices are available on our patient information website page for viewing as well as to print out and keep on file if the patient chooses. http://dentistinlexingtonky.com/patient-info/

*You May Refuse To Sign This Acknowledgement

I have received a copy of Brewer Family Dental's Notice of Privacy Practices.

Please Print Name _____

Signature _____ Date _____

Brewer Family Dental
2505 Larkin Rd #102
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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)