(PLEASE PRINT)

Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

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

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ 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. 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(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Phone Numbers

Home (_____) _____ Work (_____) _____ Ext _____ Cell Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

Dental History

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

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

Bad breath	☐ Yes	☐ No	Burning sensation on tongue	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Chew on one side of mouth	☐ Yes	☐ No	Mouth pain, brushing	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
			Clicking or popping jaw	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
			Dry mouth	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
			Fingernail biting	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
			Food collection between the teeth	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
			Foreign objects	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
			Grinding teeth	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
			Gums swollen or tender	☐ Yes	☐ No	Sores or growths in your mouth	☐ Yes	☐ No
			Jaw pain or tiredness	☐ Yes	☐ No	How often do you floss? _____		
			Lip or cheek biting	☐ Yes	☐ No			
			Loose teeth or broken fillings	☐ Yes	☐ No	How often do you brush? _____		

Dental Registration and History

Health History

Physician's Name _____ Date of last visit_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

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

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis Type _____	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
			High Blood Pressure	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No			
Cortisone Treatments	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date_____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name_____

Phone (_____)_____

Allergies

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other_____

☐ Latex _____

Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?_____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature _____ Date_____

Doctor's Signature _____ Date_____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?_____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature _____ Date_____

Doctor's Signature _____ Date_____

Gentle Dental of Branchburg
Dr. Darren Brenner Dr. Christopher Fears
Family, Cosmetic & Implant Dentistry
www.gentledentalofbranchburg.com
3461 US Highway 22 East drb@darrenbrenner.com
Branchburg, NJ 08876 908-203-1998

DENTAL HISTORY

Are any family members current patients? O Yes O No	Name of previous dentist	
Date of last dental visit	How long since last cleaning?	Reason for changing
Describe any current dental problems		

APPREHENSION

O Yes O No	Do you experience fear of having dental treatment performed? Anything specific?
O Yes O No	Have you had any unpleasant dental experiences?
O Yes O No	Have you ever received laughing gas in a dental office?
O Yes O No	Have you ever received any other kind of sedation for treatment?
O Yes O No	Do you dread the numbing side effects?
O Yes O No	Do you feel you need any help overcoming fear?

YOUR SMILE

O Yes O No	Do you think you have a pretty smile?
O Yes O No	Have you had any cosmetic dentistry?
O Yes O No	Are your teeth crooked? Does this bother you? O Yes O No
O Yes O No	Do you have any fillings or blemishes on your teeth that look bad?
O Yes O No	Would you like to have whiter teeth?
O Yes O No	Is there anything that you feel could make your smile look better? Please Describe

TEETH PROBLEMS

O Yes O No	Are your teeth sensitive to hot, cold, sweets or pressure?
O Yes O No	Does food regularly wedge between certain teeth?
O Yes O No	Do you have any areas that are hard to floss?

HEADACHES AND FACIAL PAIN

O Yes O No	Do you have frequent headaches?
O Yes O No	Do you experience popping or clicking upon opening or closing?
O Yes O No	Do your jaw or facial muscles ever get tired or sore after chewing, sleeping, stress, etc?
O Yes O No	Do you experience facial muscle pain while chewing or when you wake up?

GUM PROBLEMS

O Yes O No	Do your gums ever bleed when you brush or floss?
O Yes O No	Have your gums receded or pulled away from your teeth?
O Yes O No	Do you have bad breath or bad tastes?

Insurance and Financial Policy
Dr. Darren G. Brenner DMD, LLC

My staff and I believe that you deserve the best care. We will always present you with the ideal dental solutions possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some do not. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know:

**please initial each bullet after reading and sign on the bottom*

- Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits, please contact your employer or insurance company directly. Dental benefit/insurance plans will never pay for complete dental care. It is only meant to assist you.

- We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list) and Dr. Brenner is a preferred provider with many other plans *(including; Aetna PPO, Cigna PPO, Delta Premiere, Guardian PPO and MetLife PPO).* This means that we work with many different companies; therefore it is impossible to give you a guaranteed quote at the time of service. **We estimate your portion based on the most up-to-date information we have, but it is only an estimate**. If you would like to know a more accurate insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment, but will give you a more accurate estimate of out of pocket expenses.

- It is important that you recognize that the insurance you have is a legal contract between you and your insurance company. Our office is not, and cannot be part of that legal contract. **We will bill your insurance as a courtesy**. If insurance does not pay within 90 days, we reserve the right to request payment in full for services provided and you can collect monies due from the insurance company. Ultimately, you are responsible for all charges incurred in our office. We balance bill for what your insurance does not cover. For major work, such as crowns, implants, bridges and partials, we request a portion of the fee be paid at the start of treatment to cover the costs incurred from the laboratory.

- We accept Visa, MasterCard, Discover, cash and check. If you are in need of an extended finance option, we also work with Care Credit, who offer 3,6,12 or 18 month "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit.

- If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

- A finance charge will be imposed on each item of your account which has not been paid within ninety (90) days of the time the item was added to the account. The finance charge will be computed at the rate of 1.5% per month or an annual percentage rate of 18%. The finance charge on your account is computed by applying the periodic rate (1.5%) to the overdue balance of your account. The overdue balance of your account is calculated by taking the balance owed 90 days ago, and then subtracting any payments or credits applies to the account during that time.

- There is a fee (currently $25) for any checks returned by the bank.

- If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay the lawyer's fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Somerset County, New Jersey.

- In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

- You will need to request in writing and pay a reasonable copying fee (currently $25) if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including payment history.

- A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we ask for at least 24 hour notice to avoid a $40/hour cancellation fee (family emergencies are an exception).

I agree with the above conditions

Print Name:_____ Date:_____

Patient/Parent Signature:_____

GENTLE DENTAL OF BRANCHBURG

Dr. Darren Brenner & Dr. Christopher Fears

Family, Cosmetic & Implant Dentistry

3461 US Highway 22 East, Branchburg, NJ 08876

Phone: 908-203-1998 Fax: 908-203-1448

REQUEST FOR RELEASE OF DENTAL RECORDS

Date:_____

To: _____

_____

_____

Fax: _____

I, _____, authorize the release of my dental records and x-rays to Gentle Dental of Branchburg.

Patient Name:_____

Patient Signature:_____

Relationship to Patient:_____

Patient Address:_____

_____

DIGITAL X-RAYS MAY BE SENT TO:
drb@darrenbrenner.com

CONSENT FOR USE, DISCLOSURE AND AUTHORIZATION FORM

Patient Name:_____

DOB:_____

As used in this form, the words "I," "me," "my" and similar references means the patient whose name appears above, or the parent, legal guardian or other legally responsible person on behalf of the minor or incapacitated patient named above.

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

General Consent for Examination and Treatment

I hereby consent and authorize ***Gentle Dental of Branchburg*** and all staff, to perform a full dental head and neck examination and to take any necessary radiographs to help diagnose diseases of the oral cavity and underlying structures.

Acknowledgment of Receipt of Notice of Privacy Practices

I have read and understand ***Gentle Dental of Branchburg's*** HIPAA Notice of Privacy Practices, which contains information on the uses and disclosures of my protected health information (PHI). Our Notice provides a description of our treatment, payment activities, and healthcare operations.
A copy of Notice accompanies this Consent.
I understand that ***Gentle Dental of Branchburg*** has the right to change its HIPAA Notice of Privacy Practices from time to time and that whenever an important change is made, will post a new notice in the office. I may contact ***Gentle Dental of Branchburg*** at any time to obtain a current copy of the HIPAA Notice of Privacy Practices. Those changes may apply to any of your protected health information that we maintain. I may also access a copy on the website

www.gentledentalofbranchburg.com

Consent For Use and Disclosure of Protected Health Information for Treatment, Payment and Health Care Operations

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information (PHI) to carry out treatment, payment activities, and healthcare operations, including contacting specialists on your behalf.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting ***Gentle Dental of Branchburg*** :

- Dr Darren Brenner- 3461 Route 22 East, Branchburg, NJ 08876
- Telephone: 908-203-1998; Fax – 908-203-1448
- Email: drb@darrenbrenner.com

_____Initial please

Disclosures to Authorized Individuals

I, or Authorized Individual (if patient is a minor) understand that ***Gentle Dental of Branchburg*** may release my PHI to the below listed family member, friend or other person indicated. Please be sure to list any parent and/or guardian if patient is a minor.

I designate the following person(s) listed below as a person or persons involved with my health care and/or payment for my health care-

Full Name:_____ Relationship:_____

Full Name:_____ Relationship:_____

Full Name:_____ Relationship:_____

Full Name:_____ Relationship:_____

I HEARBY AUTHORIZE *GENTLE DENTAL OF BRANCHBURG* TO SHARE:

- ○ Any of my dental/medical information
- ○ My appointment dates and times and reasons for the visits
- ○ Medications I may be taking or prescribed
- ○ The following information (specify): _____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to ***Gentle Dental of Branchburg***. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we recieved your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Consent for Electronic Correspondence

I HEARBY AUTHORIZE *GENTLE DENTAL OF BRANCHBURG* to contact me via the following:

- ○ **Phone call**
- ○ **Email**
- ○ **Text message (text message charges may apply)**

Consent and Authorization

I have read and understand the terms of this document. I have had an opportunity to ask questions about the use or disclosure of my health information and about the contents of this form. I acknowledge, consent and agree to the terms and conditions of this document:

Patient Name:_____ Date:_____

Patient Signature:_____

Authorized Individual (if patient is a minor) Name:_____

Relationship to patient:_____