Brook Trout Dental, PC

(307) 234-6671
brooktroutdental@gmail.com

Thank you for selecting Brook Trout Dental for your dental needs. Please complete the following confidential information. ***Please Note:*** A copy of your insurance information and Photo ID are requested prior to your appointment.

Date:

PATIENT INFORMATION				DENTAL INSURANCE Primary Insurance	
Patient Name		Goes By		Name of Insured	
If Child, Parent's Name				Employer	Work Phone ( )
Address				Card Provided *(circle one)* Yes No Don't Have	Date Employed
City/State/Zip				Insurance Carrier	Group or Policy #
Email Address *(used for Confirmations or BTD Notifications Only)*				SSN	Certificate # *(if known)*
Phone Numbers *(please include all that apply)*				**Secondary Insurance**	
Land Line ( )				Name of Insured	
Cell Phone ( )				Employer	Work Phone ( )
Spouse's Phone ( )				Insurance Carrier	Group or Policy #
Best Phone to Text for Appt Reminders ( )				SSN	Certificate # *(if known)*
				If either insured's address is different, provide info below:	
Birthdate	Age	Male	Female		
Single	Married	Divorced	Widowed		
Social Security Number				Phone ( )	*Circle One:* Primary Secondary
ACCOUNT INFORMATION Person Financially Responsible for the Account				Relationship *(circle one)* Father Mother Other	
Name				**EMPLOYMENT INFORMATION Patient or Parent**	
Mailing Address *(if different from above)*				Name	Birthdate
City/State/Zip				Employer	Occupation/Shift
Best Phone(s)		Relationship		Business Location	Phone ( )
Method of Payment	Cash	Credit Card		**YOUR SPOUSE**	
				Name	Birthdate
PERSON TO CONTACT FOR EMERGENCY				Employer	Occupation/Shift
Name				Business Location	Phone ( )
Phone(s)		Relationship		**We're Pleased to Have You as a Patient. How Did You Hear About Our Office?** *(If referred, please tell us who.)*	
Closest Relative Not Living With You					
Name					
Phone(s)		Relationship			

Thank you for choosing Brook Trout Dental as your dental provider. We are committed to your treatment being successful. Please understand that payment of your fees is considered part of your treatment. The following is a statement of our Financial Policy, which we ask that you read and agree to sign prior to treatment.

- **All patients must complete the Patient Information Form, this Financial Policy Form and Medical History Form** before seeing the doctor.

- **Please be aware that patients only are allowed in the operatory. This includes children.** I understand this. *(Please sign)* ____.

- **Missed Appointments**—It is office policy to call and confirm dental appointments the business day prior to the appointment. Thus, **unless cancelled at least 24 hours in advance, we charge for missed appointments.** Please help us to better serve you and others by keeping a scheduled appointment or by letting us know in advance if that appointment needs to be changed.

Please be aware that confirmed no call/no show appointments are grounds for dismissal from the practice.
I have read and understand this. *(please initial)* ______

If you have dental insurance and your eligibility has been proven, then we are willing to bill the insurance for the portion they cover for checkups & cleanings. The balance not covered by the insurance is expected date of treatment. Billing insurance on your behalf is done as a courtesy to you. It is important that you are aware that having insurance is not a guaranteed form of payment. Please realize that some and perhaps all of the services provided may not be covered and you are responsible for any balance owed. Forms of payment include cash, debit card, Visa, Mastercard, and Care Credit (OAC) payment plan. Checks are only accepted from established patients.

Thus, we request that a credit or debit card be kept on file to be processed automatically for any portion not covered by the insurance plan. **I have read and understand this.** *(Please initial)* ____

Note: This does include patients on Equality Care (Title 19) and the Delta Dental Kid Care Chip programs. Occasionally eligibility is no longer in effect and we must have recourse when that occurs.

Please complete the following or discuss with the receptionist if you have any questions.

Credit Card Information (check those that apply) ____ Debit ____ Visa____ Mastercard ____ Care Credit

Card #1____ Expiration:_____/_____ Code on back ____

Card #2____ Expiration:_____/_____ Code on back ____

Name on Cards: 1) ____ 2) ________________________________

Consent for Treatment

1) I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate to make a thorough diagnosis of ______________________________________' dental needs.
2) Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3) I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications if I so choose.
4) I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protections of my personal health information is available.
5) I, the undersigned patient/guardian, agree to pay for all services that are rendered to myself or the patient immediately upon demand by Brook Trout Dental. I further agree that in the event of non-payment to Brook Trout Dental of any amounts due under this agreement, I will pay interest at the rate of 2% on all amounts due, a late fee of $20 per month until paid in full, and all attorney fees and court costs that may be incurred. I further agree that in the event that Brook Trout Dental assigns this account to an agent for collection I promise to pay an additional collection fee of 35% of any unpaid balance.

I have read this agreement and understand its provisions.

______________________________ ______________________________ ____________
Patient or Parent/Guardian Signature | Relationship to Patient | Date

Health History Form

As required by law, Brook Trout Dental adheres to written policies and procedures to protect the privacy of information about you we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. We do not use it to discriminate.

Name ______________________ Date ______________

Do you have any of the following diseases or problems?:

Active Tuberculosis (TB)	Yes No	Persistent Cough greater than 3 week Duration	Yes No
Cough that Produces Blood	Yes No	Been Exposed to Anyone with TB	Yes No

If you answered yes to any of the four items above, please stop and return this form to the receptionist.

Dental Information *Please circle the proper response.*

Do your gums bleed when you brush or floss?	Y N	Do you have earaches or neck pain?	Y N
Are your teeth sensitive to hot/cold?	Y N	Do you have clicking, popping, locking of the jaw?	Y N
Does food or floss catch between your teeth?	Y N	Do you grind your teeth?	Y N
Is your mouth dry?	Y N	Do you have sores or ulcers in your mouth?	Y N
Have you had any periodontal gum treatment?	Y N	Do you wear dentures or partials?	Y N
Have you ever had braces on your teeth?	Y N	Do you participate in active sports?	Y N
Have you had problems associated w/previous dental treatment?	Y N	Have you ever had a serious injury to your head or mouth?	Y N
Is your home water supply fluoridated?	Y N	Have you had oral surgery?	Y N
Do you drink bottled or filtered water?	Y N	Do you mouth breath when asleep?	Y N
If yes, how often? (circle) Daily Weekly Sometimes	Y N	Are you concerned about bad breath?	Y N
Are you experiencing dental pain/discomfort now?	Y N	Do you smoke or chew tobacco?	Y N
What is the reason for your dental visit today?		How do you feel about your smile?	
Date of last Dental Exam *(approximate is fine)*		Were x-rays taken? If so, which office took them?	Y N

How often do you have dental examinations? ______________Are you happy with this pattern? Yes No
How often do you brush your teeth? ________________ Floss? _______________ Do you use toothpicks, interplax, etc.? Yes No Have you ever had an upsetting dental experience? Please describe.

Are you nervous about today's visit? Yes No If so, why?

Medical Information

Are you allergic to *(circle all that apply)* Penicillin Sulfa Drugs Local Anesthetic Aspirin Codeine Latex

Are you under the care of a physician? Yes No If yes, who? ______________________Ph. (___)________
Date of last physical exam ________________ Have you had a serious illness or operation that involved hospitalization in the last five years? Yes No Reason for procedure:

Are you taking or have you recently taken any prescription or over the counter medications? Yes No
If yes, please list name and purpose of the medication:

Medical Information

Please answer the following questions

Question	Yes	No	Question	Yes	No
Do you wear contact lenses? …………………………….....	❒	❒	Do you use controlled substances (drugs)?	❒	❒
Joint Replacement: Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?.......... Date: _________ If yes, have you had any complications?	❒ ❒	❒ ❒	Do you use tobacco (smoking, snuff, bidis)? .... If yes, are you interested in stopping……………………….…………… Do you drink alcoholic beverages?	❒ ❒ ❒	❒ ❒ ❒
Are taking or scheduled to begin taking either of the Medications, Alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease?	❒	❒	If yes, how much did you drink in the last 24hrs? ___________________________ If yes, how many do you typically have in a week? ___________________________		
Since 2001, were you treated or are you scheduled to begin treatment with the intravenous bisphosnates (Aredia or Zometa) for bone pain hypercalcemia or Skeletal complications resulting from Paget's disease, Multiple myeloma or metastatic cancer? …………...	❒	❒	Are you current taking birth control pills or any other form of hormonal replacement? .... Are you currently pregnant? ……………………………….……………... If yes, how far along are you? ____	❒ ❒	❒ ❒

Allergies- Are you allergic or have had any reaction to: (If yes, please specify the type of reaction that occurred.)	Yes	No	Allergies (If yes, please specify the type of reaction that occurred)	Yes	No
Local anesthetics: ___________________________	❒	❒	Metals___________________________	❒	❒
Aspirin:___________________________	❒	❒	Latex (rubber)___________________________	❒	❒
Penicillin or other antibiotics:___________________________	❒	❒	Iodine ___________________________	❒	❒
Barbiturates, sedatives, or sleeping pills___________________	❒	❒	Hay fever/ seasonal ___________________________	❒	❒
Sulfa drugs ___________________________	❒	❒	Animals___________________________	❒	❒
Codeine or other narcotics ___________________________	❒	❒	Food ___________________________	❒	❒
			Other___________________________	❒	❒

Please indicate with an "X" if you have or have not had any of the following diseases or issues.

Condition	Yes	No
Artificial (prosthetic) heart valve……………………………...……	❒	❒
Previous infective endocarditis……………………………...... ………..	❒	❒
Damaged valves in transplanted heart…………………………………..	❒	❒
Congenital Heart Disease (CHD)………………………………….….	❒	❒
Unrepaired, cyanotic CHD……………………....................	❒	❒
Repaired (completely) in the last 6 months…………………	❒	❒
Repaired CHD with residual defects…………………….……	❒	❒

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD

Condition	Yes	No	Condition	Yes	No
Cardiovascular disease..	❒	❒	Mitral valve prolapse.......	❒	❒
Angina……………………	❒	❒	Pacemaker…………..….	❒	❒
Arteriosclerosis………….	❒	❒	Rheumatic Fever….........	❒	❒
Congestive heart failure..	❒	❒	Rheumatic heart disease	❒	❒
Damaged heart valves….	❒	❒	Abnormal bleeding….......	❒	❒
Heart attacks…………….	❒	❒	Anemia……..……………..	❒	❒
Heart murmur……..……..	❒	❒	Blood transfusion.……….	❒	❒
Low blood pressure……	❒	❒	If Yes Date:___________		
High blood pressure…..	❒	❒	Hemophilia…..……………	❒	❒
Other congenital heart defects……………………	❒	❒	AIDS/HIV infection.……..	❒	❒
			Arthritis……..……………	❒	❒

Condition	Yes	No	Condition	Yes	No
Autoimmune disease……	❒	❒	Hepatitis, Jaundice or liver disease ……..………	❒	❒
Rheumatoid arthritis……..	❒	❒	Epilepsy………..…..……	❒	❒
Systemic lupus Erythematosus…….…...	❒	❒	Fainting spells or seizures......	❒	❒
Asthma……………….…..	❒	❒	Neurological disorder…… If Yes Specify:__________	❒	❒
Bronchitis………………..….	❒	❒	Sleeping disorder…..	❒	❒
Emphysema…………..….	❒	❒	Mental health disorder….. If Yes Specify:__________	❒	❒
Sinus trouble………..…...	❒	❒	Recurrent Infections......... If Yes Specify:__________	❒	❒
Tuberculosis………..……	❒	❒	Kidney disorder…..	❒	❒
Cancer/Chemotherapy / Radiation Treatment…….	❒	❒	Night sweats…………	❒	❒
Chest pain in exertion.….	❒	❒	Osteoporosis………..	❒	❒
Chronic pain……….…..…	❒	❒	Persistent swollen glands in neck……………………	❒	❒
Diabetes Type I or II…….	❒	❒	Severe headache migraines…	❒	❒
Eating disorder.……..…..	❒	❒	Severe or rapid weight loss….	❒	❒
Malnutrition………..…….	❒	❒	Sexually Transmitted Disease.	❒	❒
Gastrointestinal disease...	❒	❒	Excessive urination………	❒	❒
G.E. Reflux/persistent heartburn………………...	❒	❒			
Ulcers…………………….	❒	❒			
Thyroid problems…..……	❒	❒			
Stroke……………………	❒	❒			
Glaucoma……………..…	❒	❒			

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? If yes, which antibiotic? ❒ ❒

Name of physician making recommendation: Phone:

Do you have any disease, condition, or problem not listed above that you think I should know about?... ❒ ❒
If yes, please explain:

NOTE: Both Doctor and staff are encouraged to discuss any and all relevant patient health issues prior to treatment.
I clarify that I have read and understand the above and that the information given is accurate. I understand the importance of a truthful heath history and my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff responsible for any action they take or do not take because of errors or omissions that I have made in the completion of this form.

SIGNATURE OF PATIENT/LEGAL GUARDIAN: DATE:

FOR COMPLETION BY DENTIST

COMMENTS:____
____
____
____
____
____

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected my health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment both directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed of the ability to obtain Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I have been given the right to review such Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below 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, healthcare operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: ____

Signature: ____

Relationship to Patient: ____

Date: ____________________

Brook Trout Dental, PC
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Casper, WY 82601