



Dr. Thad L. Brown III Dr. Bryan D. Copeland

Please take a few minutes to fill out this form as completely as you can. Also, please review and complete the Office Policy form. If you have any questions, we will be glad to help.

Name _____ M F Preferred Name _____ Age _____	
Birthdate ____/____/____ Driver's License # _____ Social Sec. # ____-____-____	
Address _____ City _____ St _____ Zip _____	
If a P O Box, please also provide street address _____	
Email address _____ Single Married Other (spouse name _____)	
Home Phone _____ Cell # _____ May we text you on your cell phone? Y N	
Work # _____, can you receive calls at work? Y N	
Employer _____ Occupation _____	
Who may we thank for referring you? _____	
Or circle one: TV Radio Newspaper Internet Insurance Provider Yellow Pages Billboard	
Contact in case of emergency _____ Phone # _____	

Name of Dental Ins. Co _____ PLEASE PROVIDE COPY OF INSURANCE CARD AT FIRST VISIT.	
Who is responsible for this account? _____ Relationship _____	
Parent or Insured's Name _____ Employer _____	
Address _____ City _____ State _____ Zip _____	
Phone # _____ Social Security # ____-____-____ Birthdate ____/____/____	
Insurance ID # _____ Group # _____	
Secondary Dental Insurance (If applicable)	
Insured's name _____ Birthdate ____/____/____	
Social Security # ____-____-____ Employer _____	
Address _____ City _____ State _____ Zip _____	
Insurance Company Name _____ Group # _____	
Insurance ID # _____	

Dental History	
1. Purpose of this visit _____	
2. How long since last dental visit? _____	Date of last dental xrays? _____
3. Have you had any allergic reaction from dental treatment? _____	Explain _____
4. Do you clench or grind your teeth? _____	When? _____
5. Have you experienced problems with your jaw? _____	Clicking Popping Pain
6. Have you experienced any soreness or lumps in your face/mouth? _____	Where? _____
7. Does food get caught in your teeth? _____	Where? _____
8. Are you sensitive to: Hot Cold Sweets Chewing Pressure	
9. Do your gums bleed or hurt? _____	When? _____
10. How often do you brush? _____	Floss? _____
11. Have you had gum surgery? _____	When? _____ Where? _____
12. Are your teeth: Loose Shifted Chipped Cracked Discolored	
13. Do you snore or have difficulty sleeping? _____	Explain _____
14. Do you play high contact sports? _____	If yes, do you wear a mouthguard? _____
15. Are you unhappy with past dental treatment? _____	Explain _____
16. Are there old fillings or dental work that you don't like? _____	Explain _____
17. Are you unhappy with the appearance of your smile? _____	Why? _____
18. What would you like to change most about your smile? _____	

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Medical History

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care. Please answer each question, or circle YES or NO where applicable.

1. Are you in good dental health?.....Yes No
2. Are you under the care of a physician?.....Yes No
If so, what is the condition(s) being treated? _____
3. Physician's name _____ Date of last exam _____
Address _____ Phone # _____
4. Have you ever had any serious illness or operation?.....Yes No
If so, what illness or operation? _____
5. Have you ever been hospitalized?.....Yes No
If so, what was the problem? _____
6. Are you taking any medication?.....Yes No
If so, what and how much? _____
7. Are you taking any recreational drugs (marijuana, cocaine, etc)?.....Yes No
Please note that some recreational drugs taken within 24 hours of dental treatment could be fatal.
8. Are you sensitive or allergic to any drugs? **Penicillin** **Sulfa Drugs** **Aspirin** **Codeine** **Other**
If other, please list _____
9. Are you taking any medications for osteoporosis? Y N If so, what? _____
10. **Do you require PRE-MEDICATION (with antibiotics) for your dental treatment for heart murmur, MVP, artificial joints or other health concerns not listed?..... Yes No**
11. Please check if you currently have or have had any of the following:

AIDS/HIV	_____	Congenital Heart Problem	_____	Heart Murmur	_____	Recent Weight Loss	_____
Anemia	_____	Cortisone Medication	_____	Hemophilia	_____	Respiratory Disease	_____
Agina/Chest Pain	_____	Diabetes	_____	Hepatitis/Jaundice	_____	Rheumatic Fever	_____
Arthritis	_____	Drug Addiction	_____	High Blood Pressure	_____	Rheumatism	_____
Artificial Prosthesis	_____	Epilepsy/Seizure	_____	Joint Replacement	_____	Scarlet Fever	_____
Asthma	_____	Emphysema	_____	Kidney Disease	_____	Sinus Trouble	_____
Blood Disease	_____	Excess Bleeding	_____	Latex Allergy	_____	Tobacco Use	_____
Blood Transfusion	_____	Fainting Spells	_____	Liver Disease	_____	Thyroid Disease	_____
Cerebral Palsy	_____	Hay Fever	_____	Mental Disorder	_____	Tuberculosis	_____
Chemotherapy	_____	Head Injuries	_____	Nervous Disorder	_____	Ulcers	_____
Cancer	_____	Heart Attack	_____	Phen Fen/Redux	_____	Venereal Disease	_____
Cold Sore	_____	Heart Failure	_____	Radiation Treatment	_____	Other	_____

11. Do you wear a cardiac pacemaker or have you had heart surgery?.....Y N
12. Do you have any conditions or problems not listed? _____ If yes, please explain _____

(Women) Are you pregnant, or is there a possibility you could be pregnant? Y N
Nursing? Y N Taking Birth Control? Y N

I certify that the above information is complete and accurate. If any changes occur to my health, I will advise the office immediately. I understand that I am responsible for full payment of each procedure at, or prior to, the time of treatment. I agree to give 24 hours notice if I change an appointment. I grant permission for Dr. Thad L. Brown III and/or Dr. Bryan D. Copeland to take any necessary x-rays, administer anesthetics, and to employ such operative and technical procedures as necessary or advisable for the diagnosis and treatment of the above patient. All records, including photographs, are the property of the office.

Print Name _____

Signed _____ Date _____
(Signature of patient, or parent/guardian)

Dr. Brown and Dr. Copeland's Office Policy

Time Commitment

A scheduled appointment is a commitment of time between you and our doctor/hygienist. We reserve that time just for you. When an appointment is missed or cancelled on short notice that time is lost instead of being used by another patient. We make every effort to honor all time commitments and we request of you to extend the same courtesy to us. Our office usually confirms appointments 24 hours in advance. Please advise the office if you need to change your appointment at that time. We reserve the right to charge an office visit fee for appointments missed or cancelled without a 24 hours prior notice. Missing an appointment, or arriving 15 minutes late or more, could result in dismissal from the practice.

Dental Insurance

We are happy to bill your dental insurance carriers, on your behalf at no charge. The benefits that are actually paid by insurance carriers vary widely from carrier to carrier and group to group, and depend primarily on the benefits negotiated and paid for by your employer, union, or other group with the insurance carrier. Very often we can provide you with an approximate **estimate** of your coverage prior to treatment. However, we cannot guarantee the insurance payment as estimated. Hence, **any treatment rendered to you will be your financial responsibility irrespective of what your insurance pays.** With your signature (below) you accept our policy and authorize Thad L. Brown III, DDS and/or Bryan D. Copeland, DDS to 1) Bill your insurance carriers on your behalf; 2) release any information regarding treatment at this office to your insurance carrier(s); 3) authorize payment directly to Thad L. Brown III, DDS and/or Bryan D. Copeland, DDS any insurance benefits due to services rendered. Please check one:

_____ Option 1. I request that Brown and Copeland Dentistry bill my dental insurance. I agree to pay any estimate that Brown and Copeland Dentistry require the day of my treatment, and any balances left after my insurance payment.

_____ Option 2. I plan to pay my bill in full. I will file with my insurance company for reimbursement, or I do not have insurance.

Please inform the dental assistant if you have had x-rays taken at another dental office in the past five years. Insurance may not cover certain procedures if they have been done in another office. Brown and Copeland Dentistry is not responsible for any balances left by insurance due to treatment performed in another dental office.

Payment in full

Payment is required on the day of your appointment. If you have dental insurance, your estimated co-payment and deductible are due on that day.

Payment Options

For your convenience, we accept cash, check, and all major credit cards (Visa, MasterCard, American Express, and Discover). Furthermore, our office offers applications for easy to use financing programs, the most popular being CareCredit, which offers up to 18 months interest free** financing with no penalty for early payoff. How do you plan to pay for your portion of your treatment?

Cash Check Credit Card Finance Program**

Interest free option only available on certain amounts; **Financing is subject to application approval.**

Please be aware that any past due accounts turned over to our collection agency will be subject to collection fees, which are normally a percentage of your balance due. By signing below, I agree that any collection or servicing agency or agencies retained to collect any money due Dr.'s Brown and/or Copeland may contact me by telephone or text message at any number given by me or associated with my account, including but not limited to cellular/wireless numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by autodialing devices and through pre-recorded messages, artificial voice message or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide or is otherwise associated with my account.

Notice of Privacy Practices

Our office obeys federal and state law regarding the privacy of your health information. With your signature below you acknowledge the receipt of our office's Notice of Privacy Practices as well as the policies listed above.

Print Patient's Name _____

Patient or

Parent/Guardian

Signature _____ Date _____

I would like the following people to be given any access to my health information, including but not limited to health history, appointments and diagnoses.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____