We Cater to Cowards

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____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 #___________________Work #____________________________
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?____

CONTINUED ON BACK

Patient Name________________________________Birthdate______________

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. Do you require **pre-medication (with antibiotics)** for your dental treatment?…………..…………………… Yes No
9. Are you sensitive or allergic to any drugs? **Penicillin** **Sulfa Drugs** **Aspirin** **Codeine** **Other**
   If other, please list________________________________
10. Do you have or have you had any of the following:

Condition	Y	N	Condition	Y	N	Condition	Y	N	Condition	Y	N
Anemia	Y	N	Heart Murmur	Y	N	Recent Weight Loss	Y	N	Thyroid Disease	Y	N
Hemophilia	Y	N	Angina/Chest Pain	Y	N	Epilepsy/Seizure	Y	N	Cerebral Palsy	Y	N
Rheumatism	Y	N	Heart Failure	Y	N	Nervous Disorder	Y	N	Blood Transfusion	Y	N
Scarlet Fever	Y	N	High Blood Pressure	Y	N	Respiratory Disease	Y	N	Excess Bleeding	Y	N
Diabetes	Y	N	Mitral Valve Prolapse	Y	N	Tuberculosis (TB)	Y	N	Blood Diseases	Y	N
Glaucoma	Y	N	Congenital Heart Prob	Y	N	Emphysema	Y	N	Latex Allergy	Y	N
Arthritis	Y	N	Hepatitis/Jaundice	Y	N	Asthma	Y	N	Smoke	Y	N
Cancer	Y	N	Liver Disease	Y	N	Sinus Troubles	Y	N	Chew Tobacco	Y	N
Ulcers	Y	N	Kidney Disease	Y	N	Venereal Disease	Y	N	Drug Addiction	Y	N
Hay Fever	Y	N	Joint Replacement	Y	N	Fainting Spells	Y	N	Cortisone Med	Y	N
Cold Sore	Y	N	Artificial Prosthesis	Y	N	Chemotherapy	Y	N	Phen Fen/Redux	Y	N
Stroke	Y	N	Head Injuries	Y	N	Radiation Trtmt	Y	N	AIDS/HIV	Y	N
Heart Attack	Y	N	Mental Disorder	Y	N	Rheumatic Fever	Y	N	Others	Y	N

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.
Signed____________________________________Date____________

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 appointments frequently 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.

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.

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_______________