THOMAS R. O'BRIEN, DDS, INC.
GENERAL & SPORTS DENTISTRY

PATIENT INFORMATION:

Today's Date ____________________

SSI# ____________________

Patient Name ____________________

Address ____________________

City ____________________

State ____________________ Zip ____________________

E-mail Address ____________________

Gender ☐ M ☐ F Age ____________

Birthday ____________________

☐ Married ☐ Widowed ☐ Single

☐ Separated ☐ Divorced

Occupation/Job Title ____________________

Patient Employer/School ____________________

Employer/School Address ____________________

____

Employer/School Phone (______) ____________________

Spouse's Name ____________________

Birthday ____________________

SSI# ____________________

Whom may we thank you for referring you? ____________________

DENTAL INSURANCE:

PRIMARY INSURANCE
Who is responsible for this account? ____________________

Relationship to Patient ____________________

Insurance Co. ____________________

Subscriber ID # ____________________ Group # ____________________

Is patient covered by additional insurance? ☐ Yes ☐ No

SECONDARY INSURANCE
Subscriber's Name ____________________

Birthday ____________________ SSI# ____________________

Relationship to Patient ____________________

Insurance Co. ____________________

Subscriber ID # ____________________ Group # ____________________

ASSIGNMENT AND RELEASE
I certify that I, and/or my dependent(s), have insurance coverage with ____________________ and assign directly to
Insurance Company(ies)

Dr. Thomas R. O'Brien, DDS., Inc. 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.

Dr. Thomas R. O'Brien, DDS, Inc. 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 Representative

____
Please print name of Patient, Parent, Guardian or Representative

____________________ ____________________
Date Relationship to Patient

PHONE NUMBERS:

Home (______) ____________________ Cell (______)____________________ Work (______) ____________________ Ext ______

Spouse's Work (______) ____________________ Best time and place to contact you ____________________

EMERGENCY CONTACT PERSON

Name ____________________ Relationship to Patient ____________________

Home Phone (______) ____________________ Cell 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
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you brush? ____________________

How often do you floss? ____________________

HEALTH HISTORY:

General Physician's Name ______________________ Date of last visit ______________

Have you taken any of the group drugs collectively referred to as "fen-phen", including 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:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting and/or Dizziness	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Arthritis (Rheumatism)	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis Type A	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Bleeding Abnormally (with extractions or surgery)	☐ Yes	☐ No	Hepatitis Type B	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
			Herpes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Swollen Feet and/or Ankles	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tumor(s) [Location: ________)	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Cough (persistent or bloody)	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Weight Loss (unexplained)	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Do you wear contact lenses?	☐ Yes	☐ No

IF YOU ARE A WOMEN:
Are you pregnant? ☐ Yes ☐ No Due date ______________ Are you nursing? ☐ Yes ☐ No
Currently on birth control? ☐ Yes ☐ No

CURRENT MEDICATIONS:

List any medications you are currently taking and reason:

____

____

Pharmacy Name ______________________

Phone (______) ______________________

ALLERGIES:

☐ Aspirin
☐ Local Anesthetic
☐ Barbiturates (Sleeping pills)
☐ Penicillin
☐ Codeine
☐ Sulfa
☐ Iodine
☐ Other ______________
☐ Latex

____

FUTURE MEDICAL UPDATES: (Filled out during future appointments)

Have there been any change(s) in your family's health since your last dental appointment? ☐ Yes ☐ No

Please specify: ______________________________

Are you taking any <u>new</u> medications? ☐ Yes ☐ No If so, what? ______________________

Patient's Signature ______________________ Date ______________

Doctor's Signature ______________________ Date ______________

Have there been any change(s) in your family's health since your last dental appointment? ☐ Yes ☐ No

Please specify: ______________________________

Are you taking any <u>new</u> medications? ☐ Yes ☐ No If so, what? ______________________

Patient's Signature ______________________ Date ______________

Doctor's Signature ______________________ Date ______________

THOMAS R. O'BRIEN, DDS, INC.
GENERAL & SPORTS DENTISTRY

DEAR INSURANCE PATIENT,

For over 30 years, it has been Dr. O'Brien's policy to accept assignment of insurance benefits for payment of services rendered. As you well know, there has been many changes in coverage options and benefits paid over the past 30 years, especially in the last 15 years. It has become increasingly difficult, time consuming and expensive for our staff to extend this service to you as insurance companies have deliberately become evasive and cunning in avoidance of payment of these routine dental claims.

In an effort to hold down our fee(s), it has become necessary to alter our policy as follows:

> *Payment is still expected in full when service is rendered. We will continue to file your primary insurance as a courtesy to you. You are responsible for payment of your portion of the fee(s) that we estimate at the time treatment is rendered. It is your responsibility to supply us with complete, updated information necessary to file this claim. If for any reason you are unable to supply this information at the time of service, we will ask you to pay in full and we will give you proper receipt necessary to file the claim yourself. Additionally, if payment from the insurance company is delayed for any reason, 45 days from the date of treatment, the balance is due immediately from you and it is your responsibility to negotiate with your insurance company from that point on. We are unable to file secondary insurance, as this typically takes up to six months to receive payment.*

We regret that something so simple in the past has become so complicated today. We hope you understand our position on this subject.

Sincerely yours,

Dr. Thomas O'Brien & Staff

DR. THOMAS O'BRIEN & STAFF

I have read this above information and understand fully Dr. Thomas O'Brien's policy on payment of services involving insurance coverage.

______________________________ ____________________

Signature of Patient — Date of Signature