# CONFIDENTIAL PATIENT INFORMATION

**ADA**
American Dental Association

Dr. Lawrence Brannon, D.M.D, M.A.G.D, P.C.
683 Berkmar Court
Charlottesville, Va. 22901

Date: ____________________

Referred by: ________________

Name: Last ____________ First ____________ Middle ____________ Nickname ______

Address: ________________________________ Best Contact # ______________

Date of Birth: __________ Sex: _______ Marital Status: _________ SS#: ____________

Person Responsible for Account: Name ____________________ SS#: ______________

Address: ________________________________________________

Phone (H) ______________ (C): ______________ Email: ______________

Please tell us who we can thank for referring you: ______________________________

**EMPLOYER** (Patient)

Name: ____________________

Company: __________________

Address: __________________

Phone: ____________________

Occupation: _________________

**EMPLOYER** (Parent/Spouse)

Name: ________________________

Company: ______________________

Address: ______________________

Phone: ________________________

Occupation: ____________________

**DENTAL INSURANCE**

**Primary**: Policy Holder Name : ______________________________
SS# ____________________ Date of Birth: ______________________

Insurance Company: ____________________ Address: __________________
ID#: ____________________ Group Policy # ______________________

**Secondary Insurance**: Policy Holder Name: __________________________
SS#: ____________________ Date of Birth: ______________________

Insurance Company: ______________________ Address: ______________
ID# ______________________ Group Policy # ____________________

In Case of an Emergency, Notify: Name ____________________ Phone: ______________

*This Signature authorizes the practice to release dental information for insurance purposes. It also certifies that the information on this registration form is Correct and that, if insured, the benefits are assigned directly to this practice. If I do not pay the entire new balance within sixty days of the monthly billing date, A service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month(or a minimum charge of $5.00) Which is an annual percentage rate of 18% applied to the last months balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection cost and reasonable attorney fees incurred to effect collections of this account or future outstanding accounts.*

Signature of person responsible for account ________________________________

## DENTAL HEALTH INFORMATION

LAST DENTAL VISIT? ________________ LAST XRAYS? ________________

ARE YOU HAVING ANY IMMEDIATE DENTAL ISSUES? ________________

HAVE YOU HAD ANY PERIODONTAL TREATMENT? ________________

DO YOU GRIND/CLENCH YOUR TEETH? ________ FOOD TRAPS? ________

ANY HEADACHES, EARACHES? ________________ CLICKING/POPPING IN JAW ________________

ANY ORTHODONTIC/BRACES TREATMENT? ______ WHEN? ________

HAVE YOU HAD YOUR WISDOM TEETH REMOVED? ________________

DO YOU HAVE ANY LOOSE TEETH OR SENSITIVITY? ________________

HOW DO YOU FEEL ABOUT THE APPEARANCE OF YOUR SMILE? ________

________________________________________________

## MEDICAL INFORMATION

ANY SERIOUS OPERATIONS OR ILLNESSES? ________ IF YES, DESCRIBE ________________

ANY JOINT REPLACEMENTS? ________________ PREMED/ANTIBIOTIC? ________

ANY ALLERGIES TO MEDICATIONS, ANESTHETICS, METALS, OR LATEX?

________________________________________________

ARE YOU PREGNANT? ________________

TOBACCO USE? ________ WHAT TYPE? ________________

HAVE YOU HAD ANY OF THE FOLLOWING: ASTHMA CANCER DIABETES

EPILEPSY HEPATITIS A,B,C HIGH OR LOW BLOOD PRESSURE,

RHEUMATIC FEVER OSTEOPOROSIS

HEART CONDITIONS ________________

OTHER CONDITIONS NOT LISTED ________________

________________________________________________

PLEASE LIST ANY MEDICTIONS YOU ARE CURRENTLY TAKING. ________

# HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The Patient has the right to restrict the uses of their information.
- The Patient may revoke this Consent in writing at any time and all future disclosures will then cease.

This HIPAA Consent was signed by: ______________________ ______________________

Signature of patient or guardian     Printed name of same

Relationship to the patient (if other than patient): ______________________ ______________________

Please print     Today's Date

I give my permission to discuss my treatment and or billing information with: ______________________

Relationship to patient (check one):

☐ Spouse ☐ Parent ☐ Child ☐ Grandparent ☐ Grandchild ☐ Legal Guardian

☐ Attorney (or representative) of patient ☐ Other: ______________________