



6301 N. Oak Trfwy, Suite 201 ■ Gladstone, MO 64118
office: 816.413.8285 fax: 816.413.8662 www.BrobstFamilyDentistry.com

Thank you for selecting Brobst Family Dentistry for your dental care. We are committed to providing quality care, and look forward to meeting you.

We have enclosed our medical history forms with the basic information needed for your medical records. Please bring the following information and forms with you:

- Photo ID
- New patient forms
- List of your current medications- including the dosage. If you need to bring your medications in, make sure they are in the prescription bottle.
- All current insurance cards
- Should your insurance carrier require a referral or an authorization, please bring that with you.

If you need to scheduled an appointment or If you would like more information, please call our office 816.413.8285.

For patients with mobility challenges with ambulating or transferring to an exam chair, please inform our staff prior to your visit.

Use the space below to record your information.

Appointment Date: _____ Appointment Time: _____ am. | pm.

Our office is located at **6301 N. Oak Trafficway, Suite 201**, Gladstone MO 64118.

We look forward to seeing you.

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: Policy Holder Responsible Party Preferred Name: _____ Date _____

RESPONSIBLE PARTY (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

PATIENT INFORMATION

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____

E-mail: _____ I would like to receive correspondences via e-mail.

DENTAL INSURANCE Do you have Dental Insurance: YES | NO Do you have Secondary Insurance: YES | NO

To save you time, we'll make copies of your insurance cards.
Please remember to bring them with you to your first appointment.

Patient Registration (Continued)

Nearest relative not living with you: _____ Phone: _____

Whom may we contact in case of an emergency?

_____ Phone: _____

Whom may we thank for referring you to us:

_____ Phone: _____

Physician: _____ Phone: _____

Preferred Pharmacy: _____ Phone: _____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature (parent if minor) _____
Date

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows (Edward B. Brobst, DDS, 6301 N. Oak Trafficway, Gladstone, MO 64118.) This payment will not exceed my fees incurred to the assignee and I have agreed to pay in a current manner any balance due. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

A photocopy of this assignment shall be considered as effective and valid as the original.

Signature (parent if minor) _____
Date

MEDICAL HISTORY

Patient Name: _____ Birth Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes _____

Have you ever been hospitalized or had a major operation? Yes No If yes _____

Have you ever had a serious head or neck injury? Yes No If yes _____

Are you taking any medications, pills or drugs? Yes No If yes _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes _____

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No If yes _____

Women: Are you ...

Pregnant/Trying to get pregnant? Nursing Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Metal Penicillin Codeine Sulfa Drugs Local Anesthetics

Other If yes _____

MEDICAL HISTORY - continued

Patient Name: _____

Birth Date: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/ Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problems	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Swelling of limbs	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blister	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No
				Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No		

Have you ever had any serious illness not listed above? Yes No

If yes _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: _____

X

Date _____

Dental History

Patient's name _____ Date of birth _____

Date of last dental visit _____ What was done? _____

Have you had a complete series of dental films (x-rays) taken? Yes No

When and where _____

How often do you brush your teeth? _____ How often do you floss? _____

	Yes	No
Are your teeth sensitive to hot or cold liquid/foods?	_____	_____
Are your teeth sensitive to sweet or sour liquid/foods?	_____	_____
Do you feel pain to any of your teeth?	_____	_____
Do you have any sores or lumps in or near your mouth?	_____	_____
Have you had any head, neck or jaw injuries?	_____	_____
Have you ever experienced any of the following problems in your jaw?		
Clicking	_____	_____
Pain (joint, ear, side of face)	_____	_____
Difficulty in opening or closing	_____	_____
Difficulty in chewing	_____	_____
Do you have frequent headaches?	_____	_____
Do you clench or grind your teeth?	_____	_____
Do you bite your lips or cheeks frequently?	_____	_____
Have you noticed any loosening of your teeth?	_____	_____
Does food tend to become caught between your teeth?	_____	_____
Have you ever worn a bite plate or appliance?	_____	_____
Have you ever had any difficult extractions?	_____	_____
Have you ever had any prolonged bleeding after an extraction?	_____	_____
Do you wear dentures or partials?	_____	_____

If you could change anything about your smile, what would you change?

Gum Disease May Relate to Heart Attack Risk

Previous studies have found the incidence of heart disease is about twice as high in people with periodontal (gum) disease, but until recently no plausible cause had been suggested. Now studies indicate that the most common strain of bacteria in dental plaque may cause blood clots. When blood clots escape into the bloodstream, there is a relation to increased risk of heart attacks and stroke.

People with periodontal disease (over one half the adult population) have an infection that causes chronic inflammation of the gums. Also, it is a path for these bacteria to enter the bloodstream.

A recent study describes the association between heart disease and gum disease to be at least as strong as the linkage of heart disease to cholesterol, body weight or smoking.

American Dental Association Warning Signs of Periodontal Disease

Don't wait until it hurts. Periodontal disease is painless. It affects 75% of the population and often patients are unaware.

	Yes	No
Do your gums bleed when you brush your teeth?	___	___
Are your gums red, swollen or tender?	___	___
Have your gums pulled away (receded) from your teeth?	___	___
Do you have pus between your teeth and gums when pressed?	___	___
Are your permanent teeth loose or separating?	___	___
Have your teeth changed the way they fit when biting?	___	___
Has there been any change in the fit of your partial dentures?	___	___
Do you have persistent bad breath?	___	___

Incidence of Periodontal Disease

Unlike most disease that give us early warning signs, gum disease progresses silently, often without pain. It may develop slowly or progress quite rapidly. More than half of all people over 18 have at least the early stages of periodontal disease. Even more frightening, after the age of 35, three out of four people are affected to some degree. Periodontal disease is an infection that destroys the gum surrounding your teeth and also destroys the supporting bone that holds your teeth in place.

Periodontal disease may increase your risk for a variety of health concerns including:

- weakened immune system • diabetes • strokes • lung disease • preterm births
- respiratory disease • osteoporosis • gastric ulcers

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature (parent if minor)

Date

Notice of Privacy Practices Acknowledgement (HIPAA)

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected 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 the treatment directly and indirectly.
- Obtain payment for third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time 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 or healthcare operations. I also understand you are not required to agree to my request restrictions but if you do agree then you are bound to abide by such restrictions.

Patients name _____

Relationship to patient _____

Signature _____

Date _____

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement but was unable to do so as documented below.

Date _____ Initials _____ Reason _____