REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date_____

SS#_____

Patient Name_____

Address_____

City_____State_____Zip_____

How Long?_____ Rent ☐ Own☐

E-mail_____

Sex ☐M ☐F Age_____ Birth Date_____

☐Married ☐Widowed ☐Single ☐Minor☐

Separated ☐Divorced ☐Partnered For____Years

Occupation_____

Employer_____

Spouse's Name _____

Spouse's Birth Date_____

Spouse's SS# _____

Spouse's Employer _____

Whom may we thank for referring you?_____

HIPAA RELEASE AND CONSENT:

Acknowledgement of Receipt of Notice of Privacy Policies
I,_____,have received a copy of Brown & Kress DDS, Notice of Privacy Policies. I understand Brown & Kress DDS may use my health care information and may disclose such information for treatment, payment, and health care operations.

_____Printed Name

_____ Signature & Date_____

2 DENTAL INSURANCE

Who is financially responsible for this account?

_____

Relationship to Patient_____

Insurance Co._____

Group#_____

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber's Name_____

Birth Date_____ SS#_____

Relationship to Patient_____

Insurance Co._____

Group #_____

Insurance Assignment
I certify that I, and/or my dependents(s), have insurance coverage

with_____and assign directly to
Name of insurance company(ies)

Brown & Kress DDS all insurance benefits, if any, otherwise payable to us for services rendered.

Financial and Personal Health Information
I understand that I am financially responsible for all charges incurred during treatment. I further understand that any insurance contract is between my insurance carrier and myself and Brown & Kress DDS is not part of that contract. As a courtesy to our valued patients we will submit your insurance forms initially. If problems occur with insurance portion of your obligation, the balance in full will become due in 30 days. We will provide information to help you deal with your carrier. I understand that finance charges will begin 90 days from date of service if the balance is not paid in full. I au-thorize the use of my signature on all insurance submissions.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Home (_____)_____Work (_____)_____Ext _____ Cell Phone (_____)_____

Spouse's Work (_____)_____Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name_____ Relationship_____

Home Phone (_____)_____ Work Phone (_____)_____

4 HEALTH HISTORY UPDATE

To be updated at your future dental visits

Date Of Visit	Changes To Health History / Medication	Detail Changes Initials
1._____	YES_____ NO_____	_____
2._____	YES_____ NO_____	_____
3._____	YES_____ NO_____	_____

5 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
Sore or growths in your mouth	☐Yes	☐No

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

6 HEALTH HISTORY

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐Yes	☐No	Fainting or Dizziness	☐Yes	☐No	Respiratory Disease	☐Yes	☐No
Anemia	☐Yes	☐No	Glaucoma	☐Yes	☐No	Rheumatic Fever	☐Yes	☐No
Arthritis, Rheumatism	☐Yes	☐No	Headaches	☐Yes	☐No	Scarlet Fever	☐Yes	☐No
Artificial Heart Valves	☐Yes	☐No	Heart Murmur	☐Yes	☐No	Shortness of Breath	☐Yes	☐No
Artificial Joints	☐Yes	☐No	Heart Problems	☐Yes	☐No	Sinus Trouble	☐Yes	☐No
Asthma	☐Yes	☐No	Hepatitis Type_____	☐Yes	☐No	Skin Rash	☐Yes	☐No
Back Problems	☐Yes	☐No	Herpes	☐Yes	☐No	Special Diet	☐Yes	☐No
Bleeding abnormally, with extractions or surgery	☐Yes	☐No	High Blood Pressure	☐Yes	☐No	Stroke	☐Yes	☐No
Blood Disease	☐Yes	☐No	Jaundice	☐Yes	☐No	Swollen Feet or Ankles	☐Yes	☐No
Cancer	☐Yes	☐No	Jaw Pain	☐Yes	☐No	Swollen Neck Glands	☐Yes	☐No
Chemical Dependency	☐Yes	☐No	Kidney Disease	☐Yes	☐No	Thyroid Problems	☐Yes	☐No
Chemotherapy	☐Yes	☐No	Liver Disease	☐Yes	☐No	Tonsillitis	☐Yes	☐No
Circulatory Problems	☐Yes	☐No	Low Blood Pressure	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Congenital Heart Lesions	☐Yes	☐No	Mitral Valve Prolapse	☐Yes	☐No	Tumor or growth on head or neck	☐Yes	☐No
Cortisone Treatments	☐Yes	☐No	Nervous Problems	☐Yes	☐No	Ulcer	☐Yes	☐No
Cough, Persistent/Bloody	☐Yes	☐No	Take Oral Bisphosphates	☐Yes	☐No	Venereal Disease	☐Yes	☐No
Diabetes	☐Yes	☐No	Take IV Bisphosphates	☐Yes	☐No	Weight Loss (unexplained)	☐Yes	☐No
Emphysema	☐Yes	☐No	Pacemaker	☐Yes	☐No	Currently Pregnant	__ Yes	__ No
Epilepsy	☐Yes	☐No	Psychiatric Care	☐Yes	☐No			
			Radiation Treatment	☐Yes	☐No			

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:_____

_____

_____

Pharmacy Name_____

Phone (___)_____

ALLERGIES

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

DATE: _____

BROWN & KRESS, DDS

Cancellation Agreement

Here at Brown & Kress, DDS, we value your time and commitment to choosing us for your dental care. In doing so, we hope to establish mutual respect for each other's time. Therefore, our policy is as follows;

> Please schedule your appointments at a time that ***you*** are able to commit. We ask for your full commitment to being here when you say you can be here. We realize that things may come up, which are out of your control, which would make you have to change the appointment. If this happens, we ask you to call our office and explain to our Patient Benefit Coordinators why you need to change your appointment.
>
> If you ***fail*** to show up for your first appointment you will be placed on a same-day-only appointment policy. The definition of a same-day-only appointment is; you will need to call on a day you know you can make and we will see if we have availability in our schedule to see you.
>
> If you ***fail or cancel*** an appointment more than ***two*** times we will, unfortunately, have to dismiss you from our practice. We will give you notice in writing.

Let's build a lasting relationship! We value and respect you as our patient and would like to be your dental practice family for a very long time!

Dr. Kress, Dr. Brown, and their entire team are looking forward to a lasting relationship with you and your family. If you have any questions before your appointment, please feel free to give our office a call. We can be reached at 812-689-5151.

-Patient or Guardian Signature -Date

TRUTH IN LENDING
EXPLANATION OF INTEREST RATES, INTEREST CHARGES AND FEES

INTEREST RATES AND INTEREST CHARGES	
Annual Percentage Rate (APR) for Purchases	**15.00%**
Paying Interest	A finance charge is imposed on those charges not paid in full within 30/60/90/120 days (as shown on the front of your billing statement) of the date you were first billed for the charges. The balance on which any finance charge is computed is determined by totaling the charges not paid within the time period shown on the front of your billing statement and then by multiplying the balance by the periodic rate shown.
Minimum Interest Charge	**If you are charged interest, the charge will be no less than $0.50**

FEES	
Late Charge	**$5.00 or 5% of the past due minimum payment, whichever is greater, with a maximum of $17.50** If the minimum payment is received within 10 days after the due date the late charge will be waived.
Non-Sufficient Funds (NSF) Fee	**$25.00 per payment**

YOUR BILLING RIGHTS UNDER THE FAIR CREDIT BILLING ACT

If you think you have been billed incorrectly, or if you need more information about a transaction on your bill, write to us on a separate sheet at First Pacific Corporation, PO Box 3000, Salem, OR 97302. We must hear from you no later than 60 days after we have sent you the first bill on which the error or problem appeared. You may telephone us at 1-800-574-7064, but doing so will not preserve your rights. In your letter, please include the following information:

- Your name and account number.
- The dollar amount of the suspected error.
- Describe the error and explain why you believe there is an error. If you need more information, describe the item you are not sure about.

YOUR RIGHTS AND OUR RESPONSIBILITIES AFTER WE RECEIVE YOUR WRITTEN NOTICE

- We must acknowledge your letter within 30 days, unless we have corrected the error by then. Within 90 days, we must either correct or explain why we believe the error was correct.
- After we receive your letter, we cannot try to collect any amount you question, or report you as delinquent. We can continue to bill you for the amount in question, including finance charges and we can apply any amount against your credit limit. You do not have to pay any questioned amount while we are investigating, but you are still obligated to pay the parts of your bill that are not in question.
- If we find that we made a mistake on your bill, you will not have to pay any finance charges related to any questioned amount. If we didn't make a mistake, you may have to pay finance charges, and you will have to make up any missed payments on the questioned amount. In either case, we will send you a statement of the amount you owe and the date that it is due.
- If you fail to pay the amount that we think you owe, we may report you as delinquent. However, if our explanation does not satisfy you and you write to us within 10 days telling us that you still refuse to pay, we must tell anyone we report you to that you have a question about your bill and we must tell you the name of anyone we reported you to. When the matter is finally settled between us, we must tell anyone we report you to that it has been settled.
- If we don't follow these rules, we can't collect the first $50.00 of the questioned amount even if your bill was correct.
- Your continued use of this account constitutes your acceptance of the above stated conditions.

I agree to be responsible for all charges for dental services and material not paid by my dental benefits plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to any insurance claims.

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

BROWN & KRESS, D.D.S.
Dental Entity Name

Signature _____ Date _____

Account Name _____ Address _____

A photocopy of this document may act as an original

Form 05304IN (7-1-17)