Brunelli Dental Partners
550 Hammill Lane
Reno, NV 89511

Welcome

We know you have a choice in your dental care. Thank you for selecting us.

Please take a moment to answer these questions to the best of your knowledge, so that we may treat you in the most comprehensive and effective manner possible. We appreciate your time to provide you with the highest quality of dental care that you desire.

Name _____ Date _____
Last First MI

Social Security # _____ Birth date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____

Preference for Confirmation (please circle one):

Phone call Text Email

Dental Insurance information and person financially responsible for treatment:
(Please give front desk your insurance card)

Name of insured _____ Relationship to patient _____
Birth date _____ Social Security # _____
Name of Employer _____ Insurance Company _____

Do you have additional Insurance? _____Yes _____No If yes, Complete the following:

Name of insured_____ Relationship to patient _____
Birth date _____ Social Security # _____
Name of Employer _____ Insurance Company _____

No Dental Insurance? Ask us about our Dental Savings Plan

Whom may we thank for referring you? _____

Medical History

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.

1. Are you allergic to any of the following:
☐ Latex ☐ Penicillin ☐ Any Antibiotics ☐ Any Medications ☐ Any Metals ☐ Local Anesthetics ☐ None

2. Are you under any medical treatment now? ☐ Yes ☐ No
3. Are you taking any drugs or medications? Please list: _____
_____
4. Have you been hospitalized in the last 2 years? If so why? _____
5. Have you been seriously ill? If so what circumstances? _____
6. Have you ever bled excessively from minor cuts, previous surgery, or following tooth extraction? ☐ Yes ☐ No
7. Have you ever had injury to your face or jaw? If so what circumstances? _____
8. Do you or have you ever smoked or used tobacco products? ☐ Yes ☐ No
9. Are you taking any of the following bone density medications: Aredia, Zometa, Actonel, Boniva, Skelid, or Didronel "BISPHOSPHONATES"? ☐ Yes ☐ No
10. Have you ever taken Cortisone or similar drugs? ☐ Yes ☐ No

Women

1. Are you pregnant or think you may be? ☐ Yes ☐ No
2. Are you nursing? ☐ Yes ☐ No

Premed

1. Have you ever been advised to take **Prophylactic Antibiotics**(premed) before dental treatment? ☐ Yes ☐ No
2. Have you ever had or do you have any of the following:
☐ Heart Murmur ☐ Heart Attack ☐ Stroke ☐ Heart Surgery ☐ Heart problems ☐ **Artificial hip or joint**
☐ Prosthetic Heart Valve ☐ None ☐ Other: _____

Medical History

Have you ever had or do you have any of the following:

____ Anemia	___HIV/AIDS	____Cancer or Tumor		
____ Rheumatic Fever	____High Blood Pressure	____ Angina	____Stomach Ulcers	____ Emphysema
____ Swallowing difficulty	____Radiation treatment	____Epilepsy	____Diabetes	____ Kidney Disease
____ Arthritis	____Any Blood Disease	____Asthma	____Sinusitis	____Liver Disease
____ Glaucoma	____Thyroid gland problems	____Hepatitis	____Lung Problems	____None

1. Are your teeth sensitive to any of the following**:**
___ Hot ___Cold ___Sweets ___Biting Pressure
2. Frequent Headaches?_____
3. Do your gums bleed when brushing or flossing?_____
4. Have you noticed gum swelling or tenderness?_____
5. Do you have unpleasant taste or odor in your mouth?_____

Problems of the Jaw:
1. Clicking or popping ☐ Yes ☐ No
2. Pain (joints, ears, side of face) ☐ Yes ☐ No
3. Difficulty opening or closing ☐ Yes ☐ No

1. Have you ever had your teeth cleaned? ☐ Yes ☐ No
- How often? _____
2. Have you ever had periodontal treatment/surgery? ☐ Yes ☐ No
3. Are you anxious about dental treatment? ☐ Yes ☐ No
4. How often do you floss? _____ times per week.
5. Are you dissatisfied with your teeth or their appearance? ☐ Yes ☐ No
6. Have you ever worn braces? ☐ Yes ☐ No
7. Your immediate concerns: _____
_____

Previous Dentist Information

Previous Dentist _____
Last Full Mouth/x-rays _____
Last Complete Dental Exam _____

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 patients) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____
Signature of Patient/ Responsible Party Date

Brunelli Dental Partners

Financial Agreement

- Insured patients are required to pay their entire estimated portion at the time of service.

- We will gladly process your insurance claims and estimate the amount not covered by your insurance. Our estimates are subject to final approval by your insurance company; therefore, the amount due at our office is subject to change.

- All incurred changes are ultimately the responsibility of the patient regardless of insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, and not with your insurance company. Your insurance plan is a contract between you, your employer and the insurance company. Our office is not party to that contract or any possible restrictions.

- A service charge of 1½% per month (18% per annum) on any unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied.

- As a courtesy to our patients, we offer a 48 hour cancellation policy at no charge. However, appointments cancelled in less than 24 hours will result in a cancellation fee of $50.00 charged to the responsible patients account at our discretion.

Payment Options

- Cash/Check/Money orders
- Visa/MasterCard/Discover
- Care Credit/Citi Health Card (offers a separate line of credit to cover your family's dental needs. Ask for details.

_____ _____

Signature of Patient/Responsible Party Date