BROBERG & TIEKEN
DENTAL

9521 US Hwy 290 West, Suite 103 ● Austin, TX 78737 ● (512) 888-9453

PATIENT INFORMATION

Please Circle **Title:** Dr. Mr. Mrs. Miss **Name:** ____
First M Last

I prefer to be called: ________________ ☐ Male ☐ Female Birthdate: __________ Age: ______
SSN # __________________ Marital Status: S M D W

Home Address ____
City/State ______________________________ Zip ________________ Home Phone _________________
Employer _______________________________________ Work Phone __________________
Email Address ____ Cell Phone_____________________
How may we reach you? Home _____ Work _____ Email _____ Cell ______
Whom may we thank for this referral? __________________________________
Nearest relative *not* living with you _______________________relationship ________ Phone # ____________

Guarantor (if not same as above) – Please note: we cannot bill a non-custodial parent
Name ________________________________ Relationship __________________________________
Birth Date _______________________ SSN# ______________________
Billing Address ___________________________________ City ________________ State ____ Zip ________
Home Phone _________________________ Employer ___________________ Work Phone ______________
May we call you at work? ___________

Other Family Members (optional)

Name	Relationship	Employer/School	Work Phone

Insurance	**Primary**	**Secondary**
Insurance Co. Name		
Billing Address		
Telephone		
Group #		
Policyholder's Name		
Policyholder's SS#		
Relationship to Patient		
Policyholder's Birthdate		
Policyholder's Employer		

I hereby authorize Dr. Broberg to furnish information to insurance carriers concerning my dental condition and treatments and I hereby assign to them all payments for dental services to myself or my dependents. I understand that I am responsible for all fees regardless of insurance coverage.

Policyholder Signature ____ Date _________________________

Medical History

Although dental personnel primarily treat the area 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.

Name: ______________________ **Phone:** ______________ **Date of last medical exam:** ________

What was the exam for? ______________________ **Current Physician:** ______________________

	Y	N
Have you ever been hospitalized or had a major operation?	☐	☐
Are you under the care of a physician?	☐	☐
Have you ever had a serious head or neck injury?	☐	☐
Are you taking any medications or supplements?	☐	☐

If yes please list, the dose and how often:
(use back of paper if needed)

	Y	N
Do you take or have you taken Phen-Fen or Redux?	☐	☐
Have you ever taken Fosamax, Boniva, Actonel or any	☐	☐
other medications containing bisphosphonates?	☐	☐
Are you on a special diet?	☐	☐
Do you use Tobacco?	☐	☐
Do you use controlled substances?	☐	☐

Women	Y	N
Are you pregnant or trying to get pregnant?	☐	☐
Are you taking contraceptives?	☐	☐
Are you nursing?	☐	☐

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Penicillin
- ☐ Local Anesthetics
- ☐ Acrylic
- ☐ Codeine
- ☐ Metal
- ☐ Latex
- ☐ Sulfa Drugs
- ☐ Other

CHECK ALL THAT APPLY:

FAMILY HISTORY UNKNOWN? ☐ **YES** ☐ **NO**

	HAVE	HAD	FAMILY HISTORY
Acid Reflux	☐	☐	☐
AIDS\HIV Positive	☐	☐	☐
Alzheimer's Disease	☐	☐	☐
Anaphylaxis	☐	☐	☐
Anemia	☐	☐	☐
Angina	☐	☐	☐
Arthritis\Gout	☐	☐	☐
Artificial Heart Valve	☐	☐	☐
Artificial Joint:	☐	☐	☐
What Joint? ________			
When? ________			
Asthma	☐	☐	☐
Blood Disease	☐	☐	☐
Blood Transfusion	☐	☐	☐
Breathing Problem	☐	☐	☐
Bruise Easily	☐	☐	☐
Cancer	☐	☐	☐
Type? ________			
Chemotherapy	☐	☐	☐
When? ________			
Chest Pains	☐	☐	☐
Cold Sores\Fever Blisters	☐	☐	☐
Congenital Heart Disorder	☐	☐	☐
Convulsions	☐	☐	☐
Cortisone Medicine	☐	☐	☐
Diabetes	☐	☐	☐
Drug Addiction	☐	☐	☐
Dry Mouth	☐	☐	☐
Easily Winded	☐	☐	☐
Emphysema	☐	☐	☐
Epilepsy\Seizures	☐	☐	☐
Excessive Bleeding	☐	☐	☐
Excessive Thirst	☐	☐	☐
Fainting Spells\Dizziness	☐	☐	☐
Frequent Cough	☐	☐	☐
Frequent Diarrhea	☐	☐	☐
Frequent Headaches	☐	☐	☐
Genital Herpes	☐	☐	☐
Glaucoma	☐	☐	☐
Hay Fever	☐	☐	☐
Heart Attack\Failure	☐	☐	☐
Heart Murmur	☐	☐	☐
Heart Pace Maker	☐	☐	☐
Heart Trouble\Disease	☐	☐	☐
Hemophilia	☐	☐	☐
Hepatitis A	☐	☐	☐
Hepatitis B or C	☐	☐	☐
Herpes	☐	☐	☐
High Blood Pressure	☐	☐	☐
High Cholesterol	☐	☐	☐
Hives or Rash	☐	☐	☐
Hypoglycemia	☐	☐	☐
Inflammatory disease	☐	☐	☐
Type? ________			
Irregular Heartbeat	☐	☐	☐
Kidney Problems	☐	☐	☐
Leukemia	☐	☐	☐
Liver Disease	☐	☐	☐
Low Blood Pressure	☐	☐	☐
Lung Disease	☐	☐	☐
Mitral Value Prolapse	☐	☐	☐
Osteoporosis	☐	☐	☐
Pain in Jaw Joints	☐	☐	☐
Parathyroid Disease	☐	☐	☐
Psychiatric Care	☐	☐	☐
Radiation Treatments	☐	☐	☐
When? ________			
Recent Weight Loss	☐	☐	☐
Renal Dialysis	☐	☐	☐
Rheumatic Fever	☐	☐	☐
Rheumatism	☐	☐	☐
Scarlet Fever	☐	☐	☐
Shingles	☐	☐	☐
Sickle Cell Disease	☐	☐	☐
Sinus Trouble	☐	☐	☐
Sleep Apnea	☐	☐	☐
Did you wear a c-pap? Y ☐ N ☐			
Spina Bifida	☐	☐	☐
Stomach\Intestinal Disease	☐	☐	☐
Stroke	☐	☐	☐
Swelling of Limbs	☐	☐	☐
Thyroid Disease	☐	☐	☐
Tonsillitis	☐	☐	☐
Tuberculosis	☐	☐	☐
Tumors or Growths	☐	☐	☐
Ulcers	☐	☐	☐
Venereal Disease	☐	☐	☐
Yellow Jaundice	☐	☐	☐

HAVE EVER HAD ANY SERIOUS ILLNESS NOT LISTED ABOVE? ☐ **YES** ☐ **NO**

If yes, please explain: ____

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: ______________________ **Date:** ________

Dental History

Why have you come to the dentist today? ____
____

Are you currently in pain? ☐ Y ☐N
Manual or Electric toothbrush? Please circle one.
Do you use anything in addition to brushing or flossing? ☐ Y ☐ N
If yes, what? __________________________________
Do your gums ever bleed? ☐ Y ☐ N
Have you ever had periodontal disease? ☐ Y ☐ N
Are your teeth sensitive to heat, cold, or anything else? ☐Y ☐N

Are you happy with the way your smile looks? ______ if no, please answer the following questions:

When I see a picture of myself:
☐ I wish my teeth were whiter.
☐ My gums show too much.
☐ My top teeth don't show enough.
☐ There is too much space between some of my teeth.
☐ I have discolored areas between my teeth.

My teeth are:
☐ Crowded ☐Crooked ☐ Uneven
☐ Overlapped ☐My teeth have rough edges

Previous/Present Dentist: _________________________________
Last Visit Date: __________________
What did you like most and least about any dentist you have seen?
____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.
SIGNATURE _______________________________

The undersigned hereby authorized Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with (Name of Patient) _________________. And further authorization and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I give permission for release of any pertinent information about my health that may be necessary for proper diagnosis and treatment. You have my permission to use clinical diagnostic materials such as x-rays, models, photographs, etc. for display or teaching purposes.

Signature ____ Date ___________________

Important dental insurance information for our patients

Understanding your insurance coverage can be quite challenging. Our goal is to assist you in maximizing your benefits. We care for patients from many different companies. Each company pays an insurance premium for specific coverage which fits the company budget. Each plan is slightly different in its covered services. We encourage you to become familiar with your policy exclusions, deductibles, and required co-payments.

Our courtesy service to you includes:

1. Filing your insurance within 24 hours of your visit and requesting payment of your benefit to our office.
2. Electronically filing your insurance for short turnaround.
3. Researching your dental insurance plan to advise you of benefits available to you.
4. Re-filing your insurance a second time within 45 days.
5. Following the American Dental Association guidelines for coding procedures and filing insurance.

Our expectations of you as the owner of the policy:

1. We want you to be comfortable with our team. If you ever have any questions about your dental treatment, financial or insurance questions, or any concerns at all, we ask that you notify us as soon as possible. We will be glad to clarify any uncertainties that may arise.
2. Your portion of your treatment is expected at the time of your services. For your convenience we do accept many forms of payment including cash, check, Visa, MasterCard, American Express, and we offer third party financing, which includes both interest free programs and extended financing.
3. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
4. Realizing that dental insurance policies restrict payment for some services, use restricted fee schedules (called Usual and Customary Rates) and exclude some procedures based on prior conditions or length of time on plan. All restrictions are based on the premium paid for insurance not our fees or recommended treatment.
5. Taking responsibility for payment if the insurance company does not pay our office within 60 days.
6. Keeping our office informed of any changes in your insurance coverage or employment.

I hereby authorize Broberg & Tieken Dental, to release to my insurance company, information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Broberg & Tieken Dental. I understand I am responsible for any unpaid balance.

___________________________________ **Date__________________**

Signature of Patient/Insured

OUR COMMITMENT

At Broberg & Tieken Dental, we are committed to excellence. We feel that you deserve nothing less when it comes to your health. We use the best materials and techniques available in order to provide you with the quality you have come to expect from us.

We believe that our relationship with you, as with all relationships, needs open and clear communication. We will try to communicate all of your dental needs and estimate your financial information as soon as it becomes evident. We want you to be as informed as possible to help you in your decisions concerning your dental health.

We understand how valuable your time is, so we make every effort to remain on time. We do not double book appointments. We feel that you deserve our complete and focused attention so that we may provide the best care possible. Your reserved time is exclusively yours.

YOUR COMMITMENT

We want you to be comfortable with our team. If you have any questions about your dental treatment, financial questions, or any concerns at all, we ask that you notify us as soon as possible. We will be glad to clarify any uncertainties that may arise.

Payment for your treatment is expected at the time your services are performed. For your convenience we do accept many forms of payment including cash, check, Visa, Mastercard, American Express, and we also offer third party financing, which includes both interest free programs and extended financing.

Your scheduled appointment is reserved exclusively for you. We have a 48 hour cancellation policy in order to provide you with this personalized attention. We understand that circumstances may arise that require an appointment to be rescheduled. We are happy to change your appointment time if 48 hours notice is given. In addition to our policy, please note that if you are more than 10 minutes late to your scheduled appointment we may need to reschedule you for a later date and time.

____ ________________________

Patient/Guardian Date

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: ________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

______________________________	______________________________
Please ***print*** name of Patient	Please ***sign*** for Patient/Guardian of Patient
______________________________	______________________________
Legal Representative/Guardian	Relationship of Legal Representative/Guardian

Your comments regarding Acknowledgements or Consents: ______________________________

____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ Other ________________________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: ________________________ Relationship: ____________________________

Name: ________________________ Relationship: ____________________________

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation	☐ Text Message to my Cell Phone
☐ Home Phone Confirmation	☐ Email Confirmation
☐ Work Phone Confirmation	☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation	☐ Text Message to my Cell Phone
☐ Home Phone Confirmation	☐ Email Confirmation
☐ Work Phone Confirmation	☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message	☐ **Any of the Above**
☐ Text Message	☐ **None of the above** (opt out)
☐ Email	

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) ____

____
Signature of Privacy Officer

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