Brennan T O'Brien, DMD

125 Jefferson Davis Blvd,
Natchez MS, 39120

Welcome: Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us- we will be happy to help.

Patient Information (confidential)

Patient Name _____
Birthday_____ SS#/SIN_____ (Required) Patient's Sex ☐ M ☐F
Address _____ City _____ State_____ Zip_____
Phone: (MOBILE) _____ (HOME) _____ (OTHER) _____
Email: _____
Do you prefer to receive calls at your ☐Home ☐Work ☐Cell ☐Other
Check Appropriate: ☐Minor☐Single☐Married ☐Divorced ☐Widowed
Patient or Parent/Guardian's Employer _____ Work Phone _____
Person to Contact in Case of Emergency _____ Phone # _____

Responsible Party

Name of Personal Responsible for this Account _____Relationship to Patient _____
Address _____ Home Phone_____
Email _____Cell Phone _____
Driver License # _____ Birthday_____
Employer _____ Work Phone _____
SS#_____ Is this person currently a patient in our office? ☐ YES ☐NO

Insurance Information

Named of Insured_____ Relationship to Patient_____
Birthday _____ SS#_____ Date Employed _____
Name of Employer _____
Insurance Company _____ Group # _____ Subscriber ID _____

Insurance Authorization:
By checking this box☐

I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all submissions.
I authorize the dentist to release all information necessary to secure payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Patient Signature _____ Date _____
Parent/Guardian Signature of Minor Child _____ Date_____

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Medical History

Patient Name _____
Primary Care Physician: _____ Phone: _____

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

☐Allergy- Aspirin	☐Allergy- Codeine	☐Allergy- Latex	☐Allergies
☐Allergy- Other	☐Allergy- Peanut	☐Allergy- Penicillin	☐Allergy- Sulfa
☐Anemia	☐Arthritis	☐Artificial Joints	☐Asthma
☐Bacterial Infections	☐Blood Disease	☐Cancer	☐Diabetes
☐Dizziness	☐Epilepsy	☐Excessive Bleeding	☐Fainting
☐Glaucoma	☐Head Injuries	☐Heart Disease	☐Heart Murmur
☐Hepatitis	☐High Blood Pressure	☐HIV	☐Jaundice
☐Kidney Disease	☐Liver Disease	☐Mental Disorders	☐Nervous Disorders
☐Other	☐Pacemaker	☐Pregnancy	☐Radiation Treatment
☐Respiratory Problems	☐Rheumatic Fever	☐Rheumatism	☐Sinus Problems
☐Stomach Problems	☐Stroke	☐Tuberculosis	☐Tumors
☐Ulcers	☐Venereal Disease		

Do you have or have you had any disease, condition, or problem not listed above?

_____

Are you currently taking any medications, drugs, pills, or herbal remedies, included regular dosages of aspirin?
☐ Yes ☐No If yes, please list name and dosage.

_____

Are you allergic to any substance or medication? ☐Yes ☐No If yes, please list. _____

Dental History

What is your immediate concern? _____
Previous Dentist Name and Phone Number: _____
Date of most recent dental exam and dental x-rays:_____

I understand the above information is necessary to provide me with dental care in a safe and efficient Manner. I have answered all questions to the best of my knowledge. Should further information been needed, you have my permission to ask the respective heath care provider or agency who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient Signature _____ Date _____
Parent/Guardian of Minor Patient _____Date_____

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Financial Policy

Payment is due at the time service is rendered. We accept all major credit cards (Visa, MasterCard, Discover, and American Express), Cash, Checks, or debit cards for your convenience.

We also offer financing options with Care Credit and Scratch Pay. Please discuss these payment options with our office manager prior to your appointment date.

As a courtesy, we will be happy to file your dental insurance. Any amount determined not to be covered by your insurance company is payable at the time services is rendered. These fees may include deductibles, co-payments, certain procedures not covered by your insurance policy, and the difference between our fees and amount covered by the insurance company. As a health care provider, we must emphasize that our relationship is with you and not your dental insurance company. Your dental insurance is a contract between yourself and the insurance company.

I agree to be responsible for payment of all services rendered on my behalf or on the behalf of my dependents. I understand that payment is due at the tie of service unless other arrangements have been made. If payments are not received in a timely manner, I understand that my account be charged a late fee and/or finance charge up to 18%(APR).

We schedule our appointments so that each patient receives the right amount of time to be seen by our providers. If your schedule changes and you can not keep your appointment, please call our office so that we can reschedule your appointment and accommodate those who are waiting to be scheduled. As a courtesy we ask that you give 24 hours' notice of a cancellation or request to reschedule. If you do not call to cancel or reschedule within 24 hours advance notice, we may access a $50 "No Show" charge to your account. This charge is not covered by Insurance and will be billed directly to you.

Consent for Treatment

I hereby authorize Dr. Brennan O'Brien or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis.

Upon such diagnosis, I authorize Dr. Brennan O'Brien to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risk. I understand that I can ask for a complete recital of any possible complications.

I give consent to Dr. Brennan O'Brien or designated staff's use and disclosure of any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide qualify care will be used or disclosed and that a notice fully outlining my protection of my personal health information is available.

Patient Signature _____ Date _____
Parent/Guardian of Minor Patient _____Date_____

Email Form to O'Brien Family Dentis