Welcome to Our Practice This confidential information will help us prepare for your visit.

NAME _____
Mr. Mrs. Ms Rev. Dr.

I prefer to be addressed as _____

Birth date___/___/___ SS#_____-____-_____
Address_____PO Box _____
_____Zip _____

❑Single ❑Married ❑Divorced ❑Widowed ❑Separated

Home # _____ Work #_____Ext ____

E-mail address_____

Cell #_____

Employer _____

Address _____

Occupation_____There for____yrs

Where and when is best to reach you? _____

Who referred you to our office? _____

Other family members seen by us ___

Last dental visit ___

Seen by Dr._____for _____

Spouse's Name _____

Birth date___/___/___ Work # _____

Employer _____

Address _____

Occupation_____There for_____yrs

Account Information
Name on Account _____

❑Self ❑Spouse ❑Other

Notes:

Payment Plan Preferred:

__ Cash or personal check at time of treatment

__ Visa, MasterCard, Discover, or AMEX at time of treatment

___ I wish to establish personalized financial arrangements

Dental Insurance Information

PRIMARY
Insured Name _____

Insured Birthdate___/___/___ SS#_____-____-_____

Employer _____

Insurance Company_____Group # _____

Insurance Address_____

SECONDARY_____
Insured Name

Insured Birthdate___/___/___ SS#_____-____-_____

Employer _____

Insurance Company_____Group # _____

Insurance Address_____

As a courtesy to our valued patients, we will file claims for your insurance on your behalf. The responsibility of the insurance company is to you and it is your responsibility to see that you are reimbursed properly. Fees for services provided to insured patients are our normal fees charged to all patients for similar services. Your policy may base its allowance on a fixed fee schedule determined solely by your insurance company. The percentage of the fee paid may therefore be different than the percentage you were told by your insurance company or than the percentage listed in your benefit booklet. Lewis L Brown,D.D.S, P.A. does not participate with any insurance companies in the fee schedules they have developed. In deciding whom he should participate with the doctor has selected YOU. We respect the trust you place in us and believe that our relationship is negatively affected when third party interests are mandated. We will do our very best to see that you receive all of the benefits due you.

PLEASE TURN OVER AND COMPLETE THE ADDITIONAL INFORMATION ON BACK

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor. or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X _____ X _____ X _____

Signature of patient *(Parent or Guardian if Minor)* **Reviewed by** **Date**

CONSENT FOR TREATMENT: The undersigned hereby authorizes Dr. Brown to take X-rays, impression for diagnostic casts, photographs or any other diagnostic procedures deemed necessary to make a thorough diagnosis of the patients' oral health. I also authorize Dr. Brown to perform any and all forms of dental treatment, to use any an all dental materials and to administer medications and therapy which may be indicated. I understand the use of anesthetic or analgesic embodies a certain risk.

I further authorize Dr. Brown to employ such auxiliary personnel as may be necessary to preform diagnostic, therapeutic and laboratory procedures.

X _____ X _____ X _____ X _____

Signature of patient **Parent or Responsible Party** **Relationship** **Date**

CONSENT TO BE PHOTOGRAPHED: As Dr. Brown is committed to furthering the quality of dental education through teaching and writing, I authorize Dr. Brown to take or record slides, photographs, digital images or videos of the patient for the purpose *of* teaching, publication, or research. It is understood any photograph which depicts enough of the patient's face for the patient to be recognized shall be done only with the expressed written permission of the patient.

X _____ X _____ X _____ X _____

Signature of patient **Parent or Responsible Party** **Relationship** **Date**

FINANCIAL ARRANGEMENTS: I understand that fees for services rendered are due at the time of treatment unless previous financial arrangements have been made with this office. To maintain a high level of quality care the office does not participate in any insurance contracts. If any form of third party dental benefits are involved the office will be available to help file claims by providing the necessary documentation to have patients reimbursed directly.

X _____ X _____ X _____ X _____

Signature of patient **Parent or Responsible Party** **Relationship** **Date**

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X _____ X _____

Signature of patient *(Parent or Guardian if minor)* **Date**

Thank you for filling this form out completely. If you have questions regarding this form or any aspect of our dental practice please call.

Lewis L. Brown, D.D.S., P.A.

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Tuxedo Center, Suite 113

Atlanta, GA 30305

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