HARVEY H. BRECKNER | D.M.D., M.S.

COSMETIC & RECONSTRUCTIVE DENTISTRY

GENERAL DENTIST / FAMILY DENTISTRY

About Your Child

Today's Date_____ How did you hear about our office?_____

Name_____ He/She prefer to called_____
Last First M.I.

Birthdate ____/____/_____ Age_____ □ Male □ Female Social Security #_____

Home Address_____
Street City Zip

Preferred Pharmacy: _____
Name Address Phone Number

Person Responsible for Account

Name_____ Relationship?_____

Billing Address_____
Street City State

Home Phone_____ Work Phone_____ Cell Phone_____

Social Security #_____

Insurance Information

Primary Dental Insurance

Insurance Co. Name _____ Phone#_____ Group #_____

Insurance Co. Address _____
Street City State Zip

Insured's Name _____ Insured SS#_____

Insured's Birthdate ____/____/_____ Relationship to You_____

Insured's Employer _____

Secondary Dental Insurance

Insurance Co. Name _____ Phone#_____ Group #_____

Insurance Co. Address _____
Street City State Zip

Insured's Name _____ Insured SS#_____

Insured's Birthdate ____/____/_____ Relationship to You_____

Insured's Employer _____

Dental History

Why have you come to the dentist today? _____

When was your last dental visit?_____

Have you ever been given local anesthetic? □Yes □No
If so, any unusual/allergic reactions to it? □Yes □No

Do your gums bleed? □Yes □No If so, does this concern you? □Yes □No

Have you had difficult extractions in the past? □Yes □No

Have you had excessive bleeding following previous extractions? □Yes □No

Are you happy with your smile? □Yes □No

Medical History

ALLERGIES: Are you allergic to any of the following:

Penicillin	□Yes □No	
Codeine	□Yes □No	
Latex	□Yes □No	
Acrylic	□Yes □No	
Metal	□Yes □No	
Anesthetics	□Yes □No	
Other?	□Yes □No	**If other**, please list_____

Are you currently in good health? □Yes □No Are you currently under the care of a physician? □Yes □No

Do you or have you experienced the following? Please place a ☑ next to those that apply.

__High Blood Pressure	__Epilepsy/Seizures	__Low Blood Pressure	__Heart Trouble/Disease
__Liver Disease	__Stroke	__Tuberculosis	__Mitral Valve Prolapse
__Sinus Problems	__Joint Replacement	__COVID-19	__Kidney Disease
__Excessive Bleeding	__Blood Disorders	__HIV or Aids	__Rhuematic Fever
__Respiratory Disease	__Venereal Disease	__Fainting	__Cancer
__Hepatitis, type:____	__Radiation Treatment	__Diabetes	__Chemotherapy
__Nervous Disease	__Psychiatric Care	Other:_____	__None of the above

For Woman: Are you pregnant? □Yes □No If so, week #_____

Authorizations

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

I agree to pay a finance charge of 2% per month on all unpaid balances commencing 60 days from the service date. I further agree to pay any additional charges related to the cost of collection (including but not limited to; collection agency fees, reasonable attorney's fees, & court costs) in the even that I would fail to pay my bills.

When insurance applies:
I certify that I am covered by dental insurance and I assign directly to Dr. Breckner all insurance benefits otherwise payable to me. I understand that my dental insurance may not pay 100% of my account balance and that I am responsible for payment of all services rendered, including any co-payment and deductible that may apply. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____

Signature Date

PAYMENT IS DUE AT TIME OF SERVICE