JAMES K. BRIMHALL, D.M.D.
GENERAL & COSMETIC DENTISTRY

2300 N. CRAYCROFT, SUITE 2
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Welcome to our practice! We are looking forward to meeting you. Our office strives to foster a welcoming dental home for our patients. We will take the necessary time to listen to all your concerns and work with you to achieve your dental goals. This starts with having a personal, one-on-one conversation with Dr. Brimhall.

We feel that the best dental investment anyone can make is for a conscientious and thorough examination and diagnosis. Everyone deserves to be advised of the true conditions present in their mouth. Through this process, a customized treatment plan will be developed that looks at the big picture and not just a one-tooth-at-a-time approach. This comprehensive approach provides a way to restore and preserve the function and beauty of your teeth and health of your mouth.

The complete dental examination includes the following:

- Evaluation of your smile
- Appearance of your teeth
- Your bite
- Areas of excess wear, chips, cracks, & fractures
- TMJ (jaw joint) evaluation
- Comprehensive evaluation of the gums and bone health supporting the teeth
- Head/Neck and Oral cancer screening
- Condition of existing restorations
- Check for cavities
- Digital photographs of your teeth

Essential to this evaluation is the utilization of radiographs (x-rays) and state of the art technology, which provide invaluable information that cannot be obtained any other way. Our office employs digital technology which significantly reduces the amount of radiation used.

We are concerned with your total health and we are interested in you. Only by this systematic approach can we justify the confidence you have placed in us by allowing us to jointly assume responsibility of supervising your oral health.

All co-pays and patient portions are due at the time of service. We do bill many insurance plans as a courtesy to our patients; however, our office exclusively participates with Delta Dental. We do our best to estimate what insurance may pay, but the patient is ultimately responsible for what the insurance does not cover after any applicable adjustments are made. If this is a challenge for you, please discuss this with Angela prior to your appointment. She can help you maximize your insurance benefit whenever possible. We want you to receive the dental care you need.

Please visit our office website at **www.ilovemydental office.com**. We hope you will both see and feel the difference of what our office has to offer. Again, Welcome!

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:_____

Address:_____

Telephone:_____ Email:_____

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form you will consent to our use and disclosure of your protected health information to carry our treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

James K Brimhall DMD
2300 N Craycroft Rd Ste 2
Tucson, Arizona 85712
Phone: 520.745.1220 Fax: 520.298.4365

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I,_____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understood that, by signing this Consent form, I am giving to your use and disclosure of my portected health information to carry out treatment, payment activities and health care operations.

Signature: Date:

If this Consent is signed by a personal representative on behalf of the patient, please complete the following:
Personal Respresentative's Name:
Relationship to Patient:

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in patient's chart.

Patient Name: _____ Date: _____

Physician's Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Relationship: _____

Yes No Are you currently under the care of a physician? If yes describe: _____

Yes No Have you been advised by a physician of the need for any type of surgery, **pre medication** or treatment? _____

Yes No Have you had any surgical operation of any kind: Please describe: _____

Do you have, have you had, or been treated for, any of the following?

Yes No **Heart Disease or Condition**
Yes No **Angina/Chest Pain**
Yes No **Artificial Heart Valve**
Yes No **High Blood Pressure**
Yes No **Heart Attack**
Yes No **Pace Maker/Defibrillator**
Yes No **Stroke**
Yes No **Kidney Disorder**
Yes No **Diabetes**
Yes No **Glaucoma**
Yes No **Emphysema/Lung Disease**
Yes No **Shortness of Breath**
Yes No **Asthma**
Yes No **Tuberculosis**
Yes No **Liver Disease/Jaundice**
Yes No **Hepatitis**
Yes No **Hip or Joint replacement**
Yes No **Epilepsy/Seizures/Convulsions**
Yes No **Chemotherapy**
Yes No **Radiation therapy to Head, Neck, Jaw**
Yes No **Cancer**
Yes No **Fainting or Dizzy Spells**

Yes No **Thyroid Disease**
Yes No **Auto Immune Disease**
Yes No **Arthritis**
Yes No **Rheumatism**
Yes No **Stomach Ulcers/Colitis**
Yes No **GERD/Acid reflux**
Yes No **Bleeding Disorder**
Yes No **Anemia/Sickle Cell Disease**
Yes No **Hemophilia**
Yes No **Blood Transfusions**
Yes No **Chronic Diarrhea**
Yes No **Sinus/Nasal Problems**
Yes No **Psychiatric Treatment**
Yes No **Chemical Dependency**
Yes No **Anorexia/Bulimia**
Yes No **Hypothermia**
Yes No **HIV/AIDS**
Yes No **Herpes Simplex**
Yes No **Venereal Disease**
Yes No **TMJ problems/ Clenching/ Grinding**
Yes No **Tobacco Products**
Daily intake _____

Yes No Have you ever taken Bisphosphonate drugs for Osteoporosis or treatment for cancer? If yes: How long? _____

Yes No Any conditions not mentioned above? _____

Yes No Women: Are you Pregnant? if yes Due date: _____ Are you breast feeding? Yes No

Yes No Have you ever had an **Allergic reaction**(latex, food, local anesthesia, penicillin,) or been told not to take any medication? Please list: _____

Yes No Are you currently taking any **Prescription** Drugs of any kind? (Birth control, High blood pressure medication etc.) Please List: _____

Yes No Are you currently taking any **Nonprescription** Drugs of any kind? (aspirin, herbal supplements, recreational drug use, sugar, caffeine) Please list: _____

Yes No Do you wish to speak to the Doctor Privately about anything? _____

I certify the above to be true and correct to the best of my knowledge. I will notify you of any changes.

Signature _____ Date: _____

JAMES K. BRIMHALL, DMD, PLLC **DATE:**_____ **PATIENT INFORMATION**

Patient's Name _____

Preferred Name_____ Birthdate_____

Address_____
STREET CITY STATE ZIP

Home Phone_____ Cell Phone_____ SS#_____

Who can we thank for referring you?_____

RESPONSIBLE PARTY INFORMATION

Name_____ Marital Status_____

Residence (if different than above)_____

Mailing Address_____

How long at this address? _____ Home # _____ Work #_____

Previous address (if less than 3 yrs.)_____

SS#_____-_____-_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ No. of years _____

Spouse's name_____ Relationship to Patient_____

SS#_____-_____-_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ No. of years _____

INSURANCE INFORMATION

Insured's Name_____ Insured ID/SS#_____

Insurance company_____ Group #_____ Local No_____

Insurance Comp. Address_____

Do you have dual coverage? YES / NO **IF YES:**

Insured's Name_____ Insured ID/SS#_____

Insurance company_____ Group #_____ Local No_____

Insurance Comp. Address_____

EMERGENCY INFORMATION

Name of nearest relative not living with you_____

Address_____ Phone #_____

I understand that where appropriate, credit bureau reports may be obtained.

SIGNATURE (Parent's if Minor Patient) _____ **Date** _____