DR RYAN COOMBS & DR SHANNON BREWER

WELCOME

Whom may we thank for referring you?_____

PATIENT INFORMATION

Name: _____DOB:_____ SS#:_____
Email:_____DL#:_____State:_____Male or Female
Address:_____
City: _____State:_____ Zip:_____
Single Married Divorced Widowed Separated Other
Cell#:_____ Hm#:_____ Wk#:_____
Emergency Contact Name:_____Ph#1:_____Ph#2:_____

INSURANCE SUBSCRIBER INFORMATION:

(Please Give Drivers License or State Issued ID And Dental Insurance Card To Receptionist)
Subscriber Name:_____DOB:_____ID#:_____
Address:_____
City: _____State:_____ Zip:_____
Insurance Co.:_____Group#:_____Ph#:_____
Employer:_____Ph#:_____Date you started job:_____

MEDICAL HISTORY

Physicians Name:_____Ph#:_____Date of last visit:_____
Height:_____ Weight:_____ ASA Classification: 1 2 3 4
Are you currently under the care of a Physician or Specialist? Yes No
Your current physical health is? Good Fair Poor
Are you currently taking any Prescriptions/Over the counter drugs or supplements? Yes No
If yes please list:_____
Have you ever been told you need to pre-medicate prior to dental or other treatment? Yes No
Are you currently pregnant? Yes No Wk#:____ Are you nursing? Yes No
Are you currently taking or have you ever taken any medication for osteoporosis? YES or NO
If yes, what is the medication? _____ Examples include: Boniva, Fosamax, Actonel, Forteo, Alendronate, Prolia (Denosumab) injection, Prolia subcutaneous, Reclast intravenous, Atelvia, Duavee, Teriparatide, Risendronate

Have you ever had any of the following diseases or medical issues? (circle all that apply)

Abnormal Bleeding	**Alcohol/Drug Abuse**	**Anemia**	**Arthritis**	**Asthma**	**Stroke**
Artificial Joints/Valve	**Blood Transfusion**	**Cancer**	**Diabetes**	**Emphysema**	**Difficulty Breathing Fainting**
Spells	**Epilepsy**	**Glaucoma**	**Hay Fever**	**HIV/AIDS**	**Shingles**
Frequent Headaches	**Heart Attack**	**Hemophilia**	**Hepatitis**	**Seizures**	**Heart Murmur**
Heart Surgery	**Pacemaker**	**Ulcers**	**Liver Disease**	**Tuberculosis**	**Kidney Disease Radiation**
Treatment	**Rheumatic Fever**	**Sickle Cell**	**Psychiatric**	**Sinus**	**High Blood Pressure**
Low Blood pressure	**Venereal Disease**	**MVP**	**Congenital Heart Defect**		**Thyroid Problems**

Other:_____

Are you allergic to any of the following?

Aspirin	**Erythromycin**	**Metals**	**Codeine**	**Jewelry**	**Penicillin**
Tetracycline	**Latex**	**Dental Anesthetics**		**Other:_____**	

"I have answered all the above truthfully and to the best of my knowledge."

_____ _____
Patient/Guardian/Guarantor Signature Date

DR RYAN COOMBS & DR SHANNON BREWER

FINANCIAL POLICY

We look forward to serving you, your family and friends for years to come.

Please take a moment to review our Financial Policy. If you have any questions at all please do not hesitate to ask. All fees incurred through services rendered at Coombs and Brewer's office by Dr. Coombs and Dr. Brewer and/or all employees and/or associates are due at the time services are rendered. All estimated co-payments and deductibles as determined by our staff will be collected prior to treatment commencing. Any portions not covered by your insurance company are the patient/guarantors responsibility and are due within 30 days of insurance benefit payment being received.

1)_____ I understand the above statement and that I am responsible for all fees incurred in this office.

2)_____ I understand I will receive a detailed estimation of all co-payments and deductible due at my appointment(s).

3)_____ I understand co-payments/deductible, as estimated by employees, are due prior to treatment commencing.

4)_____ *I understand my employer negotiated my insurance contract. If I have a dispute with my insurance company I will inform my employer.

5)_____ If my coverage is terminated or I have not updated my insurance coverage; I am fully responsible for all fees incurred regardless.

6)_____ Coombs and Brewer's office does have a $50.00 per hour cancellation/reschedule policy. Please give a minimum of 48 hours' notice to avoid fee(s)

***Coombs and Brewer's office is here to serve you and any dispute you do have with your insurance company we will assist you with handling in any and every way we can. We have an insurance specialist and she resubmits and appeals incorrectly paid claims daily. We will attempt in every way possible to make sure the insurance company is giving you every benefit allowed under the terms negotiated by your employer on your behalf.**

"I authorize Coombs and Brewer's office to provide my Insurance Company with any information needed and/or requested to process me or my dependent(s) claims for benefit payments."

_____	_____	_____
Subscriber Signature	**Print Name**	**Date**

"I authorize my Insurance Company to release all benefit payments for myself and my dependent(s) directly to Dr. Coombs and Dr. Brewer."

_____	_____	_____
Subscriber Signature	**Print Name**	**Date**

HIPPA (Health Insurance Portability Protection Act):

Please read the HIPPA document provided explaining your rights under the Health Insurance Portability Protection Act of 1996. If you would like someone to have the ability to discuss your account, treatment or appointment(s) with Doctor(s) and/or staff members we must receive authorization in writing from the account holder and/or patient.

"I have received and understand all HIPPA compliance information provided by Coombs and Brewer's office"

_____	_____	_____
Patient Signature	**Print Name**	**Date**