BROOKFIELD FAMILY DENTISTRY
THOMAS TANG.DDS
NEW ADVANCED TECHNOLOGY
YOUR CUSTOMIZED CARE

NEW ACCOUNT INFORMATION FORM

Insured's Name

(Last, First, Middle)

Address

Preferred Name

Social Security **DOB**

Please indicate by order how you prefer we contact you

1 ________ Home / Cell / Work

2 ________ Home / Cell / Work

3 ________ Home / Cell / Work

DENTAL INSURANCE COVERAGE

PRIMARY Insurance Co.

Subscriber: Self or Name

DOB

Subscriber: ID# / SS#

DOB

SECONDARY Insurance

Subscriber: Self or Name

DOB

Subscriber: ID# / SS#

DOB

NOTE OF RESPONSIBLE PARTY

Our office will submit claims on your behalf; however, insurance is a contractual agreement between the insured and the insurance company. You will be responsible for any co-payments, deductibles each time service is rendered, and for any non-paid or denied claims.

Signature: ________ **Date** ________

(if under 18, Parent or Guardian Signature Required)

PRINT SUBMIT

Dr. Thomas Tang, DDS
17185 W. North Avenue, Brookfield, WI 53005
Phone: (262) 821-1000 | Fax: (262) 821-5044
www.TangDDS.com

Brookfield Family Dentistry
Thomas Tang.DDS
New Advanced Technology
Your Customized Care

FAMILY MEMBER INFORMATION

First Name	Last Name	Sex	Relationship	Birthday

Relationship | I = Insured S = Spouse C = Child o = Other

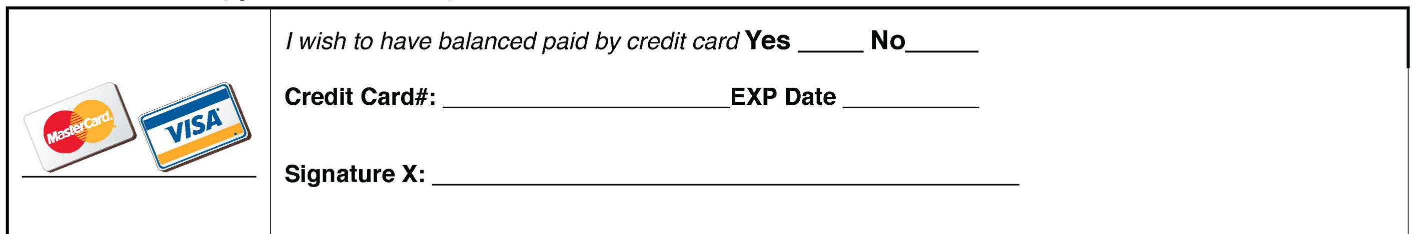
INSURANCE INFORMATION

In order to process your insurance, the Insured must sign the following:

I authorize payment of dental benefits to Dr. Thomas Tang, DDS (Brookfield Family Dentistry) for the professional services rendered. I am aware that i am responsible for all co-payments and deductibles	***Release of Information*** *I authorize the release of any dental information necessary to process this claim*
Patient X: ______________________**Date** ________ *(insured Subscriber)*	**Patient X:** ______________________**Date** ________ *(insured Subscriber)*

FINANCIAL AGREEMENTS

1. **Payments are due at the time of service. Al co-payments and deductibles are due at time of service.**
2. **If financial arrangements are needed, please speak to the Office Manager prior to treatment.**
3. **We take cash, personal checks, credit cards and assist with loans.**


I wish to have balanced paid by credit card **Yes** _____ **No**_____

Credit Card#: ____________________**EXP Date** __________

Signature X: ____

CONSENT FOR TREATMENT

1. *I hereby authorize doctor or designed staff to take Xrays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis or (name patient) ____________________________'s dental needs.*
2. *Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ assistance as required to provide proper care.*
3. *I consent to the use of appropriate medications and the therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.*
4. *I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other financial arrangements have been made. In the event* ***payments are not received*** *by agreed upon date, I understand that a 1-1/2%* ***finance charge per month, (18% APR) may be added to my account.***

Patient X: ___________________________________**Date** ______________**Witness**________________________

Patient or Responsible Party: ____________________________________**Relationship**____________________

PRINT SUBMIT

Dr. Thomas Tang, DDS
17185 W. North Avenue, Brookfield, WI 53005
Phone: (262) 821-1000 | Fax: (262) 821-5044
www.TangDDS.com

Child Health/Dental History Form

ADA American Dental Association®

America's leading advocate for oral health

Patient's Name (LAST, FIRST, INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (PO OR MAILING ADDRESS)	CITY	STATE / ZIP CODE
Phone (Home, Work)		Sex M ❑ F ❑

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ❑ Yes ❑ No

1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?

If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

❑ Anemia	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex allergy	❑ Rheumatic fever	❑ Venereal Disease
❑ Bleeding disorders	❑ Diabetes	❑ Heart	❑ Liver	❑ Seizures	❑ Other_____
❑ Bones/Joints	❑ Ear Aches	❑ Hepatitis	❑ Measles	❑ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician ______________________ Phone ______________

Child's History

	Question		Yes	No
1.	Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: ______	1.	❑	❑
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: ______	2.	❑	❑
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: ______	3.	❑	❑
4.	How would you describe the child's eating habits? ______			
5.	Has the child ever had a serious illness? If yes, when: ______ Please describe: ______	5.	❑	❑
6.	Has the child ever been hospitalized?	6.	❑	❑
7.	Does the child have a history of any other illnesses? If yes, please list: ______	7.	❑	❑
8.	Has the child ever received a general anesthetic?	8.	❑	❑
9.	Does the child have any inherited problems?	9.	❑	❑
10.	Does the child have any speech difficulties?	10.	❑	❑
11.	Has the child ever had a blood transfusion?	11.	❑	❑
12.	Is the child physically, mentally, or emotionally impaired?	12.	❑	❑
13.	Does the child experience excessive bleeding when cut?	13.	❑	❑
14.	Is the child currently being treated for any illnesses?	14.	❑	❑
15.	Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: ______	15.	❑	❑
16.	Has the child had any problem with dental treatment in the past?	16.	❑	❑
17.	Has the child ever had dental radiographs (x-rays) exposed?	17.	❑	❑
18.	Has the child ever suffered any injuries to the mouth, head or teeth?	18.	❑	❑
19.	Has the child had any problems with the eruption or shedding of teeth?	19.	❑	❑
20.	Has the child had any orthodontic treatment?	20.	❑	❑
21.	**What type of water does your child drink?** ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water			
22.	**Does the child take fluoride supplements?**	22.	❑	❑
23.	**Is fluoride toothpaste used?**	23.	❑	❑
24.	How many times are the child's teeth brushed per day? ______ When are the teeth brushed? ______	24.	❑	❑
25.	Does the child suck his/her thumb, fingers or pacifier?	25.	❑	❑
26.	At what age did the child stop bottle feeding? Age ______ Breast feeding? Age ______			
27.	Does child participate in active recreational activities?	27.	❑	❑

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

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

Parent's/Guardian's Signature ______________________ Date ______________

For completion by dentist

Comments ______________________

For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by ______________

Date ______________

© American Dental Association, 2006

Form S707

To Reorder call 1-800-947-4746
or go online at www.adacatalog.org

HIPAA FORM
PRIVACY PRACTICES INFORMATION

If you want more information about your privacy practices or have questions or concerns please contact us using the information listed at the end of this notice.

If you believe that:

- We may have violated your privacy rights,
- We made a decision about access to your health information incorrectly,
- Our response to a request you made to amend or restrict the use or disclosure of your information.
- We should communicate with your by alternative means or at alternative locations.

You may contact us in the information listed below. You also may submit a written complaint to the U.S. Dept. of Health and Human Services. We will provide you with the address to file your complaint with them upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Dept. of Health and Human Services.

Brookfield Family Dentistry
Thomas Tang, DDS
17185 W. North Avenue,
Brookfield, WI 53005
Phone (262) 821-1000
Fax (262) 821-5004

Date ____________________

I have read and understand my privacy rights

____
Signature of Patient

____
Please Print Name

____
Relationship to Patient