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

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FAMILY MEMBER INFORMATION

First Name	Last Name	Sex	Relationship	Birthday

Relationship I 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_____

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PATIENT MEDICAL HISTORY

Patient's Name			For Office Use Only	
			ID:	
Address:		**Today's Date**	**Date of Last Visit**	**Date of Med. History**
City State Zip		**Email**		
Home Phone	**Work Phone**	**Birth Date**	**Social Security #**	**Martial Status**
Primary Dental Guarantor			**Home Phone**	**Work Phone**
Secondary Dental Guarantor			**Home Phone**	**Work Phone**
Physician Name			**Physician Phone**	
Pharmacy			**Pharmacy Phone**	

For Office Use Only
Medical Alerts

Sex

If Female please answer the following

Y	N	
☐	☐	Are you taking birth control?
☐	☐	Are you pregnant?

If Yes, # of weeks? ☐

☐ ☐ Are you nursing?

Please answer the following

Y	N	
☐	☐	Do you smoke?

Office use only

BP ☐ **Heart Rate** ☐

Height ☐

Weight ☐

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Use
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Bones
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer - Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Y	N	Conditions
☐	☐	Glaucoma
☐	☐	Hay Fever
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	High Blood Pressure
☐	☐	HIV+ AIDS
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Pneumocystitis
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems

Y	N	Conditions
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Yellow Jaundice

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

Medications

_____

_____

_____

Y	N	
☐	☐	**Is there any disease, condition, or problem that you can think this office should know about that is not covered above?**

If yes, please describe below...

_____

_____

_____

_____

Notes

_____

_____

_____

Signature: _____ **Date** _____

(if under 18, Parent or Guardian Signature Required)

PRINT SUBMIT

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
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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