Welcome to Dr. Bruno's Office!

The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset. Please fill out this form completely. The better we communicate, the better we can care for you.

About You

Today's date: _____ Email address: _____

Name: (Last, First, Middle) _____

Circle one: Mr. Mrs. Ms. Dr.

I prefer to be called: _____Circle one: Male Female

Birth date: _____ Age: _____ SS #: _____

Home address: _____ City_____ State_____ Zip_____

Circle one: Single Married Divorced Widowed Separated

Home phone #: _____Work phone #: _____

Cell/pager #: _____

Employer: _____

Employer's address: _____

When & where are the best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Spouse/Parent Information

His/her name: _____

Employer: _____

Work phone #: _____

Birthdate: _____ SS#: _____

Primary Insurance

Dental Coverage: (circle one)Yes No

Insurance co. name: _____

Insurance co. address: _____

Insurance co. phone #: _____

Group # (Plan, local, or policy #): _____

Insured's name: _____ Relation: _____

Insured's birthdate: _____ Insured's SS#: _____

Insured's employer: _____

Secondary Insurance

Dental Coverage: (circle one) Yes No

Insurance co. name: _____

Insurance co. address: _____

Insurance co. phone #: _____

Group # (Plan, local, or policy #): _____

Insured's name: _____ Relation: _____

Insured's birth date: _____ Insured's SS#: _____

Insured's employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His/her name: _____ Relation: _____

Work phone #: _____ Home phone #: _____

Dental History

What are the main concerns that you would like to accomplish? _____

_____

Have you ever had or been evaluated for cosmetic treatment? (circle one) Yes No

Have you ever had a serious/difficult problem associated with any previous dental work? Yes No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Yes No

Your current dental health is: (circle one) Good Fair Poor

Do you like your smile? (Circle one) Yes No Gums ever bleed? Yes No

Have you ever had an injury to your: (circle if applicable) Mouth Teeth Chin

Do you have any speech problems? Yes No

Do you generally breathe through your mouth? (Circle one) Yes No

If yes, please circle: While awake while asleep

Do you have any missing or extra permanent teeth? (Circle one) Yes No

Medical History

Patient Name: _____

1. Have you been under the care of a medical doctor within the past two years? Yes No
   If Yes, for what _____
   Physician's name_____ Phone _____
   Address_____ City_____ State _____Zip_____

2. Have you taken **ANY** medication over the past two years? Yes No _____

3. Are you taking any medication, Drugs or pills now? Yes No
   If yes, list meds and dosage_____

4. Have you taken prescription or over the counter weight loss (diet pills)? Yes No
   If yes, did you take any of the following: Yes No Fen-Phen
   Yes No Pondimen
   Yes No Redux

If yes to any of the above, did you have a medical exam for heart issues? Yes No

5. Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes No
   If so please list: _____

6. Have you been a patient in the hospital in the past five years? Yes No
   Reason: _____

7. Please indicate which of the following you have had , or have at present:

Heart (surgery, attack. Disease)	Ulcers	Hepatitis A,B,C
Chest Pain	Diabetes	Venereal Disease
Congenital Heart Disease	Thyroid Problem	AIDS
Heart Murmur	Glaucoma	HIV Positive
High Blood Pressure	Contact Lenses	Cold sores\Blisters
Mitral Valve Prolapse	Emphysema	Blood Transfusion
Artificial Heart Valve	Chronic Cough	Hemophilia
Kidney Trouble	Tuberculosis	Sickle Cell Disease
Rheumatic Fever	Asthma	Psychiatric Care
Arthritis\Rheumatism	Tumors	Liver Disease
Cortisone Medication	Latex Sensitivity	Yellow Jaundice
Swollen Ankles	Allergies or Hives	Neurological Disorder
Stroke	Sinus Trouble	Epilepsy or Seizures
Diet (special restrictions)	Radiation Therapy	Fainting\Dizzy spells
Artificial Joints (hips, knee)	Chemotherapy	Nervous\Anxious
Heart Pacemaker	Hay Fever	Bruise Easily

8. Have you had a reaction to any type of Jewelry? Yes No

9. Have you lost or gained more then 10 pounds in the past years? Yes No

10. Do you have or have you had any disease, condition, or problem not listed above? Yes No
    If yes, please list:

11. Women: Are you Pregnant? Yes No Nursing? Yes No Taking Birth Control? Yes No

I understand the above information is necessary to provide me with dental care in a safe efficient matter. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency who may release such information to you. I will notify the doctor of any and all changes in my health or medications.

Patient\Guardian Signature _____ Date _____
History Review
Dental Signature_____ Date _____

Comprehensive Dentistry by Frank P. Bruno
6525 North Buffalo Drive, Suite 180
Las Vegas, NV 89131

Patient Policy

We are pleased to provide high quality dental services at a reasonable fee to our patients. We hope that through our office/patient relationship we can accomplish all of your oral health goals. The following are a few things that will help us care for you:

TIME

We try to adhere to a strict time schedule so patients are not kept waiting. We do try to accommodate patients who arrive late for their appointment, however, under no circumstances will we allow one patient's lateness interfere with the following patient's appointment.

We appreciate having at least 24 hours of notice if you need to cancel or reschedule your appointment. In the event that you fail to call within 24 hours to cancel or reschedule your appointment we will charge $75.00 to your account.

Patients who miss three appointments without notice within a 12 month period will not be allowed to schedule future appointments with our office.

TREATMENT

Our patients' health is very important to us. We record patient prognosis along with any treatment diagnosis at each appointment. Should a patient decline to have treatment or opt for partial treatment, we will request that a waiver of treatment be completed and signed for our records.

RECORDS

All of our patients' records are digitally recorded. We provide copies of dental records to our patients at no extra charge. We only request that patients sign a legal release to do so.

INSURANCE

We obtain pre-authorization of benefits from our patients' insurance carriers and bill insurance carriers for treatment rendered. We must be able to verify insurance coverage either by phone or computer. Therefore, we request permission to keep a copy of our patients' insurance card/information on file.

Should a minor be accompanied to an appointment by someone other than the main subscriber of their insurance policy we must have a copy of the insurance card/information on file or available to us at the time of the appointment. If the insurance card/information is not available or inaccurate, the appointment will be considered non-insured and payment will be due in full for the appointment.

Please note: Pre-authorization from an insurance carrier does not guarantee payment by that insurance carrier. If for any reason the insurance carrier does not provide payment, your account becomes immediately due in full. Coverage from more than one insurance carrier does not guarantee that you will not have an out of pocket expense. Many insurance do not coordinate benefits.

Comprehensive Dentistry by Frank P. Bruno
6525 North Buffalo Drive, Suite 180
Las Vegas, NV 89131

BILLING

We try to avoid sending monthly statements. This is accomplished by requesting payment at the time of treatment. Please do not ask for us to bill you for services already rendered. We accept payments via cash, check (in-state checks with proper ID), American Express, Discover, Master Card, Visa, and Care Credit.

There is a $25 charge for all returned checks which will be added onto your account balance.

If you would like to make monthly payments for your treatment please ask how to apply for a line of credit through Care Credit. Patients willing to pay for extensive procedures in advance may receive a discount. Payment plans are also available for treatment that is scheduled months in advance so that patients can pay in full via manageable portions leading up to their treatment.

In the event that a minor is accompanied to an appointment by someone other than their financially responsible parent or guardian please be aware that any payment for treatment will still be due at the time of the minor's appointment.

Accounts left unpaid for 90 days will sent to an outside collection agency and/or to small claims court for judgement.

By signing below you acknowledge that you have read, understand and agree to the foregoing terms and information.

_____ _____

Print Patient Name Here Date

_____ **Frank P. Bruno, DMD**

Patient/Guardian Signature Office Name

Comprehensive Dentistry by Frank P. Bruno
6525 North Buffalo Drive, Suite 180
Las Vegas, NV 89131

Consent for Treatment

Patient's Name_____ Date of Birth _____

I *CONSENT* to evaluation and medically necessary treatment by professional staff of *Comprehensive Dentistry by Frank P. Bruno, DMD*. No guarantee is being made to me about the results of treatment. I can terminate this consent for treatment at any time.

I *AUTHORIZE* doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I *AGREE* to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using an anesthetic agent embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

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 arrangements have been made.

I *AUTHORIZE* photocopies and electronic copies of this form to be as valid as the original.

The invalidity of any provision of this agreement will not affect the validity of any other provision. By signing below I acknowledge that I have read, understand, and agree to the foregoing terms and information.

_____ _____

Patient/Guardian Signature Date