HARVEY H. BRECKNER | D.M.D., M.S.
COSMETIC & RECONSTRUCTIVE DENTISTRY
GENERAL DENTIST / FAMILY DENTISTRY

Today's Date__________________ How did you hear about our office?___________________________

Name____ I Prefer to be Called______________
Last First M.I.

Birthdate ____/____/______ Age_____ ☐ Male ☐ Female Social Security #_________________

☐ Single ☐ Married, Spouse's Name ________________ ☐Divorced ☐Widowed ☐Separated

Home Address ____
Street City State Zip

Home Phone __________________________ Work Phone_________________________ Ext._______

Cell Phone ____________________________ Email Address___________________________________

Employer ____ Occupation ______________________

Employer's Addresss ____
Street City State Zip

Emergency Contact: Name________________________________ Phone Number___________________

Preferred Pharmacy: ____
Name Address Phone Number

Insurance Information

Primary Dental Insurance

Insurance Co. Name __________________________ Phone#__________________ Group #________

Insurance Co. Address ____
Street City State Zip

Insured's Name _________________________________ Insured SS#____________________________

Insured's Birthdate ____/____/______ Relationship to You_________________________

Insured's Employer ____

Secondary Dental Insurance

Insurance Co. Name ___________________________ Phone#_________________ Group #________

Insurance Co. Address ____
Street City State Zip

Insured's Name __________________________________ Insured SS#___________________________

Insured's Birthdate ____/____/______ Relationship to You__________________________

Insured's Employer ____

Dental History

Why have you come to the dentist today? ______________________________

When was your last dental visit?____________________

Have you ever been given local anesthetic? □Yes □No

If so, any unusual/allergic reactions to it? □Yes □No

Do your gums bleed? □Yes □No If so, does this concern you? □Yes □No

Have you had difficult extractions in the past? □Yes □No

Have you had excessive bleeding following previous extractions? □Yes □No

Are you happy with your smile? □Yes □No

Medical History

ALLERGIES: Are you allergic to any of the following:

Penicillin	□Yes □No	
Codeine	□Yes □No	
Latex	□Yes □No	
Acrylic	□Yes □No	
Metal	□Yes □No	
Anesthetics	□Yes □No	
Other?	□Yes □No	**If other**, please list__________________________

Are you currently in good health? □Yes □No Are you currently under the care of a physician? □Yes □No

Do you or have you experienced the following? Please place a ☑ next to those that apply.

__High Blood Pressure	__Epilepsy/Seizures	__Low Blood Pressure	__Heart Trouble/Disease
__Liver Disease	__Stroke	__Tuberculosis	__Mitral Valve Prolapse
__Sinus Problems	__COVID-19	__Kidney Disease	__Excessive Bleeding
__Blood Disorders	__HIV or Aids	__Rheumatic Fever	__Nervous Disease
__Respiratory Disease	__Venereal Disease	__Fainting	__Cancer
__Hepatitis, type:_____	__Diabetes	__Radiation Treatment	__Chemotherapy
__Psychiatric Care	Other:______________________________		__**None of the above**

Have you had a Joint Replacement? □Yes □No If yes, date:_________________

For Woman: Are you pregnant? □Yes □No If so, week #________

Authorizations

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

I agree to pay a finance charge of 2% per month on all unpaid balances commencing 60 days from the service date. I further agree to pay any additional charges related to the cost of collection (including but not limited to; collection agency fees, reasonable attorney's fees, & court costs) in the even that I would fail to pay my bills.

When insurance applies:
I certify that I am covered by dental insurance and I assign directly to Dr. Breckner all insurance benefits otherwise payable to me. I understand that my dental insurance may not pay 100% of my account balance and that I am responsible for payment of all services rendered, including any co-payment and deductible that may apply. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

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Signature Date

PAYMENT IS DUE AT TIME OF SERVICE