

Brodine Prosthodontics

Practice Limited to Prosthodontics



Alan H. Brodine, D.M.D., F.A.C.P.
Brian A. Brodine, D.D.S., M.D.S., F.A.C.P.
Board Certified Prosthodontists

220 Linden Oaks, Ste. 340 Rochester, NY 14625
(585) 248-8580 FAX (585) 248-8643
info@BrodinePros.com

PATIENT REGISTRATION

Patient's Name _____

Street Address _____ Phone () _____

City _____ State _____ Zip _____

Date of Birth _____

Marital Status: Single _____ Married _____ Widowed _____ Divorced _____ Separated _____

Name of Spouse _____ Date of Birth: _____

If a Child, Parent's Name _____

Patient Employed by _____ Phone () _____

Business Address _____

Present Position _____

Spouse Employed by _____ Phone () _____

Business Address _____

Present Position _____

Person Responsible for this Account _____

Dental Insurance Company _____

Pharmacy Name & Number _____

E-mail address (if you prefer notification of appointments by e-mail) _____

PURPOSE OF APPOINTMENT _____

REFERRED BY _____

IN CASE OF EMERGENCY, who should be Notified _____

Phone () _____

Signature of Patient, Parent or Guardian _____ Date _____

(SEE REVERSE SIDE)

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PAYMENT POLICY

SINGLE VISIT TREATMENTS (e.g., CONSULTATION, IMPLANT SURGERY)
Due on the day of the visit.

MULTIPLE VISIT TREATMENTS (e.g., CROWNS, BRIDGES, DENTURES)

- 1) 50 percent of total treatment fee is due on the day treatment begins.
- 2) The remaining 50 percent is due on the day the laboratory phase of treatment begins.

DENTAL INSURANCE:

Since insurance is not designed to pay toward complex prosthodontics:

1. Our office does not participate in any insurance plans
2. Our office does not accept insurance payments
3. We do not submit to medical insurance – only dental insurance
4. We will prepare and submit your dental insurance claim forms
5. Patients must respond to all insurance company requests

I have fully read and understand the above payment policy, and I agree to the terms and conditions referenced therein.

****We are a fragrance-free office.**

Please do not wear cologne, perfume, or strong fragrances to your appointments.

Thank you**

Person responsible
for this account:

NAME (PRINT) _____

SIGNATURE _____

DATE _____

(SEE REVERSE SIDE)

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Brodine Prosthodontics Policies on Dental Insurance

1. Dental insurance is not designed to pay for complex Prosthodontics and therefore provides little to no reimbursement for the procedures that we perform.
2. Brodine Prosthodontics does not participate and is not in network for any insurance plans or policies.
3. Brodine Prosthodontics does not accept insurance checks, does not accept assignment of benefits, and is not part of your insurance contract which is between you alone and your insurance company.
4. Brodine Prosthodontics will submit to your dental insurance on your behalf using the insurance information that you provided to us.
5. All dental insurance claims (except consults) require a current Panoramic X-ray which costs \$388 in 2022.
6. It is the patient's responsibility to respond to all insurance company requests. We only provide submission of your initial claim form to your dental insurance company. We do not respond their requests or objection/rejection of the claim.
7. Brodine Prosthodontics does not submit to medical insurance, Medicare or Medicaid.

I understand the above information.

Signature of Patient/Guardian

Date

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DENTAL INSURANCE INFORMATION

Please be sure this is your DENTAL, not Medical insurance

Patient Name: _____

Subscriber's Name: _____

Subscriber's Identification Number: _____

Subscriber's Group Number: _____

Subscriber Relationship to Patient: _____

Subscriber's Date of Birth: _____

Primary Dental Insurance:

Dental Insurance Company Name: _____

Dental Insurance Company Mailing Address: _____

Dental Insurance Company Phone Number: _____

What are the dates of extractions of all teeth you are missing?

Secondary Dental Insurance:

Secondary Subscriber's Name: _____

Secondary Subscriber's Identification Number: _____

Secondary Subscriber's Group Number: _____

Secondary Subscriber's Relationship to Patient: _____

Secondary Subscriber's Date of Birth: _____

Dental Insurance Company Name: _____

Dental Insurance Company Mailing Address: _____

Dental Insurance Company Phone Number: _____

MEDICAL HISTORY

BRODINE PROSTHODONTICS PATIENT'S NAME (PRINT) _____ DATE OF BIRTH _____
PHYSICIAN (MEDICAL DOCTOR) NAME: _____ Physician's Phone: (____) _____
Physician's office address: _____ Date last seen by physician: _____

USE PEN

CIRCLE correct answer

GIVE DETAILS as necessary

1. Are you seeing a MEDICAL DOCTOR FOR ANYTHING? YES NO
2. Are you taking ANY MEDICATION OR DRUGS? If YES, please list name and dosage YES NO

3. Have you ever had a SERIOUS BLEEDING PROBLEM? YES NO
4. Are you ALLERGIC OR SENSITIVE or have you EVER had a REACTION
(i.e., itching, rash, swelling, difficulty breathing) to ANY drugs, medications,
or injections (e.g., penicillin, erythromycin, aspirin, codeine, sulfa, dental
anesthetic) or ANY OTHER substances? YES NO
If YES, which? _____

5. CIRCLE any of the following which you have EVER had, or for which you are NOW being treated:

Osteoporosis	Pacemaker	Fainting Spells	Thyroid/parathyroid condition
Heart murmur	Rheumatic fever	Syphilis/other VD	Skin condition/rash/hives
Heart surgery	Glaucoma	Hepatitis/jaundice	Arthritis/rheumatism
Stroke	Liver condition	Drug addiction	Anemia/blood condition
Diabetes	Kidney condition	Malignancy/cancer	Cobalt or radiation treatment
Epilepsy/seizures	Asthma/sleep apnea	Artificial joint/implant	Congenital heart defect
Tuberculosis (TB)	Chemotherapy	Sinus condition	Other serious disorder/operation: _____
Lung condition	Blood transfusion	Psychiatric treatment	
Angina pectoris	Heart attack	Stomach condition/ulcer	
Heart condition	Prosthetic heart valve	High/low blood pressure	

6. Do you snore? Are you often sleepy in the daytime? YES NO
7. While sleeping, do you ever wake up short of breath? Use more than two pillows? YES NO
8. Are you on a special diet? Often thirsty? Urinate more than 8 times a day? YES NO
9. Have you been HOSPITALIZED in the past 10 years? YES NO
10. Have you ever had SERIOUS INJURIES/SURGERY of the head, face, or jaws? YES NO
11. Do you have reason to believe that you may be immune-suppressed? YES NO
12. Female: Are you pregnant? If YES, which month of pregnancy? _____ YES NO

To the best of my knowledge, all of the preceding answers are true and correct. If I have any change in my health or my medications, I will inform Dr. Brodine at the next appointment without fail.

Signature: _____ Date: _____ Dentist's signature: _____ Date: _____

REVIEW OF HISTORY

Signature: _____	Date: _____	Dentist's signature: _____	Date: _____
Signature: _____	Date: _____	Dentist's signature: _____	Date: _____
Signature: _____	Date: _____	Dentist's signature: _____	Date: _____
Signature: _____	Date: _____	Dentist's signature: _____	Date: _____
Signature: _____	Date: _____	Dentist's signature: _____	Date: _____

DENTAL HISTORY

BRODINE PROSTHODONTICS

PATIENT'S NAME (PRINT) _____

1. Approximate date of last dental visit _____
2. Approximate date teeth were last cleaned _____
3. Approximate date of last full-mouth x-rays _____
4. How often do you have your teeth cleaned _____
5. Do your gums bleed when you brush your teeth? YES NO
6. Do you have difficulty chewing your food? YES NO
7. Are any of your teeth tender when chewing? YES NO
8. Are any of your teeth sensitive to heat, cold or sweets? YES NO
9. Do you clench or grind your teeth during the day or night? YES NO
10. Is it difficult for you to open your mouth fully? YES NO
11. Do the muscles of your jaws ever feel tight? YES NO
12. Do you frequently have pain about your ear, temple or neck? YES NO
13. Do you ever have pain in your jaw joints? YES NO
14. Do you have any areas of swelling or a lump in your mouth? YES NO
15. Do you have sore areas in your mouth? YES NO
16. Have you noticed spaces developing between your teeth? YES NO

17. HAVE YOU EVER HAD:

Periodontal (gum) treatment YES NO

Name of dentist _____ City/State _____ Approx. date _____

Type of treatment _____

Orthodontic (braces) treatment YES NO

Name of dentist _____ City/State _____ Approx. date _____

Type of treatment _____

Endodontic (root canal) treatment YES NO

Name of dentist _____ City/State _____ Approx. date _____

Type of treatment _____

Oral surgery treatment YES NO

Name of dentist _____ City/State _____ Approx. date _____

Type of treatment _____

Temporomandibular Joint (TMJ) treatment YES NO

Name of dentist _____ City/State _____ Approx. date _____

Type of treatment _____

Benign or malignant oral tumor treatment YES NO

Name of dentist _____ City/State _____ Approx. date _____

Type of treatment _____

Removable prosthodontic (partial or complete denture) treatment YES NO

Name of dentist _____ City/State _____ Approx. date _____

Type of treatment _____

Fixed prosthodontic (crowns or bridges) treatment YES NO

Name of dentist _____ City/State _____ Approx. date _____

Type of treatment _____

18. Do you have any immediate dental problems that you are aware of? YES NO

19. When having dental treatment, do you prefer to have a local anesthetic (Novocain)?

ALL THE TIME _____ AS NEEDED _____ NEVER _____

20. Do you smoke cigarettes? _____ Cigar? _____ Pipe? _____ Approx. how many per day? _____

21. Do you now have or have you had any of the following habits?

Thumb sucking _____ Finger sucking _____ Cheek or tongue chewing _____

Chewing on pencils _____ Pens _____ Lips _____ Fingernails _____

22. Do you have any fear of having dentistry done? _____ If yes, why _____

23. How do you feel about the way your teeth look, feel and function? _____

Signature of patient_____
Date
(SEE REVERSE SIDE)