PATIENT INFORMATION

DATE: ____________

NAME: ____________

DATE OF BIRTH: ____________ EMAIL: ____________

ADDRESS: ____________

CITY: ____________ STATE: ____________ ZIP: ____________

HOME: ____________ CELL: ____________ WORK: ____________ EMERGENCY: ____________

MARITAL STATUS: SINGLE ________ MARRIED ________ DIVORCED ______ WIDOWED ________

SOCIAL SECURITY NUMBER: ____________ SEX: MALE ______ FEMALE ______

NAME OF EMPLOYER: ____________ DR. LIC. # ____________

RESPONSIBLE PARTY: ____________ RESPONSIBLE PARTY SOC. SEC. ____________

NAME OF SPOUSE: ____________ (IF APPLICABLE) SOC. SEC. ____________

DENTAL INSURANCE INFORMATION

DATE OF BIRTH: ____________

EMPLOYEE NAME: ____________ DR. LIC. # ____________

EMPLOYEE SOCIAL SECURITY NUMBER: ____________ NAME OF EMPLOYER: ____________

ADDRESS: ____________ PHONE: ____________

RELATIONSHIP TO PATIENT: ____________

NAME OF DENTAL INSURANCE COMPANY: ____________ GRP.# ____________

2ND DENTAL INSURANCE

DATE OF BIRTH: ____________

EMPLOYEE NAME: ____________ DR. LIC. # ____________

EMPLOYEE SOCIAL SECURITY NUMBER: ____________ NAME OF EMPLOYER: ____________

ADDRESS: ____________ PHONE: ____________

RELATIONSHIP TO PATIENT: ____________

NAME OF DENTAL INSURANCE COMPANY: ____________ GRP.# ____________

WHO MAY WE THANK FOR YOUR REFERRAL?

- ☐ 1-800-DENTIST
- ☐ INTERNET
- ☐ VALPAK
- ☐ SAVE ON EVERYTHING (SMALL BOOKLET)
- ☐ NEWSPAPER INSERT ____________
- ☐ TV CHANNEL ____________
- ☐ PATIENT REFERRAL NAME ____________
- ☐ OTHER (PLEASE BE SPECIFIC) ____________

WHO IS RESPONSIBLE FOR YOUR BILL? ____________

HOW WILL YOU BE PAYING FOR TODAYS SERVICES? CASH ____ CK ____ VISA ___ MC ___ EXP.DATE ________

REFERRED BY: ____________

*Parents: It is our office policy that whichever parent brings the child in for treatment is responsible for payment.

DENTAL INFORMATION

CHIEF ORAL COMPLAINT: ______________________________

DATE OF LAST DENTAL EXAM: ____________ CLEANING: ____________ XRAYS: ____________

ANY PREVIOUS MAJOR DENTAL TREATMENT? ☐ YES ☐ NO WHEN ____________

DO YOU HAVE OR USE ANY OF THE FOLLOWING? (PLEASE CHECK FOR YES)

TEETH SENSITIVE TO COLD, HEAT,SWEETS OR PRESSURE? ______

BLEEDING GUMS? (IF YES HOW LONG?____________) ______

FOOD IMPACTION? ______

CLENCHING OR GRINDING? ______

BURNING OF TONGUE? ______

SWELLING OR LUMPS IN THE MOUTH? ______

FREQUENT BLISTERS ON LIPS OR MOUTH? ______

PAIN AROUND EAR? ______

UNUSUAL SOUNDS IN EAR WHILE EATING? ______

UNPLEASANT TASTE? ______

COMPLICATIONS FROM EXTRACTIONS? ______

PERIODONTAL TREATMENT? ______

ORTHODONTIC TREATMENT? ______

CIGARETTE, PIPE OR CIGAR SMOKING? ______

DENTAL FLOSS? ______

DOES YOUR SPOUSE COMPLAIN THAT YOU SNORE LOUDLY? ______

MEDICAL HISTORY

Please check the box for any condition that you have had in the past or have now. (PARENT OR GUARDIAN: If you are completing this form for your child, please indicate your child's health status by checking the appropriate box.)

1. **CARDIOVASCULAR**
   - Heart failure ☐
   - Heart disease or attack ☐
   - Angina pectorals or chest pain ☐
   - High blood pressure ☐
   - Congenital heart defect or lesion ☐
   - Artificial heart valve ☐
   - Arrhythmias ☐
   - Heart pacemaker or defibrillator ☐
   - Heart surgery or Transplant ☐
   - Other heart problems ☐
   - Stroke ☐
   - Aneurysm ☐

2. **HEMATOLOGIC**
   - Blood transfusion ☐
   - Anemia ☐
   - Hemophilia ☐
   - Leukemia ☐
   - Sickle cell (anemia) disease ☐
   - Tendencytobleedlongerthannormal ☐

3. **NEURAL and SENSORY**
   - Eye pain ☐
   - Vision problems ☐
   - Glaucoma or cataract ☐
   - Earaches, ringing in ears ☐
   - Hearing loss ☐
   - Severe headaches ☐
   - Fainting or dizzy spells ☐
   - Epilepsy, seizures, or convulsions ☐
   - Nervousness ☐
   - Psychiatric treatment ☐

4. **GASTROINTESTINAL**
   - Stomach or intestinal ulcers ☐
   - Gastritis ☐
   - Colitis ☐
   - Persistent diarrhea ☐
   - Hepatitis ☐
   - Liver disease ☐
   - Yellow jaundice ☐
   - Cirrhosis ☐

5. **RESPIRATORY:**
   - Hay fever ☐
   - Sinus trouble ☐
   - Allergies or hives ☐
   - Asthma ☐
   - Chronic cough ☐
   - Emphysema ☐
   - Tuberculosis (TB) ☐
   - Breathing difficulties ☐

6. **DERMAL MUCOCUTANEOUS MUSCULOSKELETAL**
   - Allergy to latex (rubber) ☐
   - Skin rash ☐
   - Dark mole(s) (recent changes in appearance) ☐
   - Night sweats ☐
   - Sore muscles ☐
   - Stiff joints ☐
   - Arthritis ☐
   - Artificial joint ☐
   - Fever blister ☐
   - Mouth ulcers or canker sores ☐
   - Coloredordiscoloredareasinmouth ☐

7. **ENDOCRINE**
   - Diabetes ☐
   - Thyroid disease ☐

8. **URINARY—SEXUALLY TRANSMITTED**
   - Urinate frequently ☐
   - Kidney, bladder problem ☐
   - Sexuallytransmitteddisease(syphilis, gonorrhea,chlamydia,genitalherpes) ☐
   - HIV-positive ☐

9. **OTHER CONDITIONS**
   - Frequent sore throats ☐
   - Enlarged lymph node or "gland" ☐
   - Use tobacco ☐
   - Use alcohol ☐
   - Drug addiction ☐
   - Tumor or cancer ☐
   - X-ray or cobalt treatment ☐
   - Chemotherapy ☐
   - Disease, problem or condition not listed ☐
   - If yes, list

____

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	YES	NO
10. Are you currently under the care of a physician?	☐	☐
Physician name ______ Address ______		
Phone no. ______ Last appointment ______		
For what? ______		
11. Are you taking (or supposed to be taking any medicine. drugs, or pills of any kind?	☐	☐
If yes what kind and dose? ______		
12. Have you taken cortisone or other steroids in the pact 12 months?	☐	☐
13. Do you have reactions or allergies to drugs or medicines?	☐	☐
14. Have you had a reaction to dental or general anesthesia?	☐	☐
15. Have you ever had an operation or surgery?	☐	☐
Describe the problem and any complications ______		
16. Have you ever been hospitalized?	☐	☐
17. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest shortness of breath, or feeling tired?	☐	☐
18. Do your ankles swell during the day?	☐	☐
19. Do you sleep on two or more pillows?	☐	☐
20. Have you unintentionally lost or gained more than 10 pounds in the past year?	☐	☐
21. Are you on a special diet?	☐	☐
22. Does your occupation bring you into contact with blood, blood products, or needles?	☐	☐
23. WOMEN: Are you pregnant?	☐	☐

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, abnormal laboratory test, or medicine change, I will inform the dentist at the next appointment without fail.

______ Date

______ Patient, parent, or guardian signature

Height ______; Weight ______; BP ______; Pulse ______; Resp. ______; Temp. ______

HEALTH COMMENTS & SUMMARY: ASA I II III IV

______

______

______

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Office use only

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, abnormal laboratory test, or medicine change, I will inform the dentist at the next appointment without fail.

______________ ______________________________________

Date patient, parent, or guardian signature

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, abnormal laboratory test, or medicine change, I will inform the dentist at the next appointment without fail.

______________ ______________________________________

Date patient, parent, or guardian signature

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, abnormal laboratory test, or medicine change, I will inform the dentist at the next appointment without fail.

______________ ______________________________________

Date patient, parent, or guardian signature

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, abnormal laboratory test, or medicine change, I will inform the dentist at the next appointment without fail.

______________ ______________________________________

Date patient, parent, or guardian signature

APPOINTMENT CANCELLATION POLICY

If you are unable to keep your appointment, please let us know at least 24 hours in advance so that we may reschedule the time for another patient.

All appointments that are cancelled with less than a 24-hour notice will have a **$50.00** charge added to your account.

Any appointments consuming one hour or more of the doctor or hygienist's time will require 50% down of the total procedure, to hold the appointment.

Thank you for your time and understanding in this matter.

I understand and agree that I am responsible for giving a 24 hour notice if canceling any appointment, otherwise my account will be charged a* *$50.00*** *cancellation fee.*

Patient Name ______________________ Date ______________

Patient / Parent / Guardian Signature ______________________

FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

We are committed to providing you with the best possible care. If you have dental insurance, we are happy to help you receive your maximum allowable benefits. However, due to many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. Therefore, we urge you, as the patient, to please check with your insurance company prior to any office procedures. We charge what is reasonable and customary for our area. You are responsible for payment regardless of any insurance company's determination of usual and customary rates. Also, understand that not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will cover. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. It is your responsibility to know your individual coverage. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs incurred during your office visit. Please remember that your insurance policy is between you and your insurance company and not between your insurance company and your doctor.

Payments for services are due at the time services are rendered unless our staff has approved payment arrangements. We accept cash, check, Discover, MasterCard, or Visa, and offer financing through credit companies.

We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account.

We will gladly discuss your proposed treatment and answer any question relating to your insurance. If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE, do not hesitate to ask us. We are here to help you.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. Initial________

I consent to treatment by Bright Side Dental for myself and/or minor child. I have been provided the practice's statement regarding use and disclosure of my protected health information. I understand I may have a copy of this statement if I request it from the practice's privacy officer.

I authorize the release of any information necessary to process my claims and authorize payment to Bright Side Dental.

Your signature below verifies that you have read and understand this statement, and that all of your questions have been answered.

Signature________________________________ Date____________________

HIPAA Privacy Act

I consent to receive dental treatment from Bright Side Dental. I hereby authorize payment directly to Bright Side Dental of any dental services performed from the insurance company I provide. I shall be legally responsible for any out of pocket costs, such as co-pays, deductibles and services that may not be a covered benefit under the policy. I authorize Bright Side Dental to release any medical information requested in the course of my treatments to my dental insurance company.

I hereby acknowledge review of the Privacy Statement offered at Bright Side Dental and understand a copy can be provided to me. My signature is authorization for Bright Side Dental staff to contact me according to the following instructions:

Please Check YES or NO for each:

☐ Yes ☐ No OK to leave message on home, work or cell answering machine regarding my medical condition, prescription refills or billing matters.

☐ Yes ☐ No OK to leave a message with spouse, guardian or family member regarding any medical condition, prescription refills or billing matters?

Other Instructions if I'm unavailable: ______________________________

____

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I attest that the above information is correct

Signature of Patient or Guardian: ______________________________ Date: ______________

Witness Signature: ______________________________ Date: ______________

FOR OFFICE USE ONLY:

PART TWO:

Good Faith Effort to Obtain Acknowledgement of Receipt

Patient refused to sign:

Describe your good faith effort to obtain the individual's signature on this form:

____

____

Describe the reason why the individual would not sign the form:

____

____