Chart # (office use only) ____________

Patient Information

Patient name: ____ Date:__________

Last First MI

☐ Male ☐ Married Email____________________

☐ Female ☐ Single Social Security #____________

Phone____________________

Date of Birth________________

Address:____

Street City State Zip Code

Health Information

Do you premedicate for any reason? ____

Are you on blood thinners? ____

Have you had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies ____________ __________________
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Health Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due Date:__________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Other

Please list any prescription or over the counter medicine you are taking: ______________________________________
____

Have you had any complications following dental treatment? If yes, please explain. ____________________________

Have you ever been admitted to a hospital or needed emergency care during the past two years? No___ Yes (explain)_____________

Are you now under the care of a physician? If so, provide the name and phone number:___________________________

Do you have any health problems that need further clarification? If yes, please explain___________________________

Referral Information

Whom may we thank for referring you to our practice? ____

Dental History

1. Former Dentist (include address)____
2. When did you last visit a dentist? ______________________ When was your last cleaning?__________________
3. Has any dental treatment been recommended to you that you have not had done? ________________________

What concerns do you currently have with your oral health or smile? (check all that apply)

- ☐ Jaw Joint Pain
- ☐ Clenching or grinding of teeth
- ☐ Discolored teeth
- ☐ Crowding/ Crooked teeth
- ☐ Missing teeth
- ☐ Spaces in between teeth
- ☐ Loose teeth
- ☐ Unhappy with appearance of teeth
- ☐ Overbite
- ☐ Underbite
- ☐ Uncomfortable bite
- ☐ Old fillings
- ☐ Old crowns
- ☐ Speech complications
- ☐ Too much gum tissue when I smile
- ☐ Difficulty chewing
- ☐ Bad breath
- ☐ Tooth sensitivity… If so, what triggers it? ____________________________
- ☐ Food gets caught in between teeth. If yes, where? ______________________
- ☐ Other__________________

Please rate the condition of your mouth. **Poor** 1 2 3 4 5 6 7 8 9 10 **Excellent**

Do you have well water? Please circle…… YES NO

Is your water fluoridated? Please circle…… YES NO

Have you ever been treated for gum disease? Please circle…… YES NO

Do you wear a bite guard? Please circle…… YES NO

Please rate the appearance of your smile. **Poor** 1 2 3 4 5 6 7 8 9 10 **Excellent**

Would you like a whiter smile? Please circle…… YES NO

Would you like straighter teeth? Please circle…… YES NO

Have you had your teeth straightened/ worn braces? Please circle…… YES NO

Is there anything else that would be valuable for your dentist to know to best care for you?__________________________

____

- I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
- I authorize the release of any information concerning my (or my child's) healthcare, advice, and treatment to another dentist.
- I have accurately advised my dental care provider of my current health stats and any dietary or herbal supplements, medications, and/or drugs (including recreational and over the counter) that I am taking or have taken in the last week.

Patient Signature ____ Date____________________

BRIGHTSIDE FAMILY DENTAL

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of Brightside Family Dental. I hereby authorize, as indicated by my signature below, Brightside Family Dental to use and to disclose by protected health information for any necessary clinical, financial, and insurance purposes, as authorized in the Patient Consent form.

______________________________	______________________________
Print Name	Address
______________________________	______________________________
Signature	Date

Please check your preferred means of communication:

- ☐ You may contact me at my home telephone number___________________________
- ☐ You may contact me on my mobile telephone number __________________________
- ☐ You may contact me on my work telephone number ____________________________
- ☐ You may send me an unencrypted email/text message at: _______________________
- ☐ Other ____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. ____ Date Added / Removed: ____________
2. ____ Date Added / Removed: ____________
3. ____ Date Added / Removed: ____________
4. ____ Date Added / Removed: ____________

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For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (Please specify) ____

Staff person initials _____________

BRIGHTSIDE FAMILY DENTAL FINANCIAL POLICY

Assignment and Release

I, the undersigned, have insurance with ___________________________, and assign directly Brightside Family Dental all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Date: _______________________ Signature:____

(Patient or Parent / Guardian of patient)

Patient Agreement and Financial Policy

I hereby agree to be responsible for the costs of care provided by Brightside Family Dental and/or the dental team for myself or my dependent(s). These include any deductibles and amounts not covered by insurance. I also understand that it is my responsibility to be aware of any limitations, and benefits of my insurance policy. Payment to this office is my responsibility and I am aware that if the insurance company does not reimburse the doctor, I am responsible for the total amount(s).

I understand that there will be a $30 charge to all accounts in which a check payment is returned.

I understand that because appointments are not double-booked, I must provide notice of cancellation at least 48 hours prior to my scheduled appointment time. A $50 cancellation fee may apply if I do not provide notice of cancellation at least 48 hours prior to my scheduled appointment time.

We make every effort to schedule appointments that are most convenient for you and that for your personal schedule. Because we do not schedule several patients at the same time, all appointments are reserved exclusively for you. In return, we ask that you make every effort not to change your reserved dental appointment.

I understand that payment in full is due at the time of service. I understand that if I should incur an unexpected balance after 60 days, any unpaid balance will incur a $10 billing fee. I understand that failure to pay amounts due to this office will result in my account being placed with a collection agency. In the event that my account is further referred to any attorney, I agree to pay all collection and attorney fees.

Date: _________________________ Signature:_____________________________________

(Patient or Parent / Guardian of patient)

Minor/Child Consent

I, being the parent or legal guardian of ___________________, do hereby request and authorize the dental staff to perform necessary services for my child, including by not limited to radiographs (x-rays), and administration of anaesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered. I also understand that the parent or guardian who brings my child in for treatment will be responsible for payment. A receipt will be provided so I may seek reimbursement.

Signature: ______________________________________ Date: _________________

(Patient or Parent / Guardian of patient)

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient’s account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 ½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me or at my request by the doctor, I agree to pay therefore the reasonable value of said services to said doctor or his assignee of the time said services are rendered or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to by me in writing within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees should be instituted hereunder.

I grant my permission to you or your assignee to telephone me at my home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

____ Date_____________

Signature

Relationship to patient (if applicable) ____