OUR PHILOSOPY Our mission is to provide you with the finest dental care. We are here to service you and to make your dental experience as pleasant as possible. We have outlined our policies below so that we can continue our successful dental health relationship, keep our fees affordable, and accept a wide range of insurance policies.

As our partner, we ask that you assist us by following aforementioned procedures and statements; please initial the following:

Appointments are designed specifically for you

_______ We respect your time and ask that you do the same for us. We make a special effort to provide you and your family with a comfortable experience. This involves reserving a specialized time for you and your family to receive care. Should you have to change your appointment, **24 hours of notice is required in advance. If you fail to keep your appointment without 24 hours advance notice, you shall be responsible for a $28 fee for each hour missed, and a $50 fee for each hour missed with a specialist.**

Dental Insurances & Payment Policies

_______ Our insurance estimate is, in fact, an estimate, and is NOT A GUARANTEE OF PAYMENT OR COVERAGE. We will not know the final contribution from your insurance company until we receive an explanation of benefits (EOB). If for any reason your insurance company does not pay for all or part of the services rendered by Brighter Dental, you are responsible for the balance. In the event that an insurance claim has not been paid within 60 days of the service date (for any reason), you agree that you are responsible for payment to our office. In either event, you agree that you will promptly (within ten days) pay charges requested after receiving the first notice from our office. In the even that a balance goes past 90 days, an interest charge of 1.5% per month, will be billed to the account. We reserve the right to engage the services of an outside collections agency to recover outstanding balances and to bill the account all costs related to this action. If you have a third party financing program to pay for your services, you authorize the office to process any additional payments due upon receipt of any such denial or partial coverage from your insurance company.

Authorization and Release

_______ I understand that I am responsible for paying my co-payment, in full, at the time that services are rendered as well as any deductibles and/or balances that my insurance does not cover. I hereby authorize payment directly to Brighter Dental. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company. I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be protected by our Privacy Policy and it is my responsibility to inform this office of any changes in my medical status and/or dental coverage. I authorize the clinical staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

General Consent

_______ I give consent for myself/my child to receive dental treatment deemed necessary by the providers at Brighter Dental. The procedures include, but are not limited to: examinations, radiographs (x-rays), oral prophylaxis (cleanings), fluoride treatments, sealants, restorations (amalgam or composite), crowns and/or bridges, periodontal (gum) treatments with the use of local anesthetics. I understand that with the use of local anesthetics, possible adverse reactions are possible. These reaction may include, but are not limited to, the following: fainting, rapid heartbeat, light-headedness, tightness of the chest, allergic reaction, changes in pain perception and prolonged anesthesia or paresthesia, trauma to the lips and/or cheeks. There may be complications at the site of injection that may include, but are not limited to: numbness, bruising, swelling, hematoma, and jaw pain.

____ ____________________
Name of Patient (please print) Date

____ ____________________
Signature of Patient or Parent/Guardian Date

____ ____________________
Signature of Doctor Date

____ ____________________
Signature of Witness Date

Health History Form

Today's Date: ___________ Your email address: ___________________________

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that you create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information will allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: Last / First / Middle

Home Phone: *Include area code* ( )

Business/Cell Phone: *Include area code* ( )

Address: Mailing Address

City:

State:

Zip:

Occupation:

Height:

Weight:

Date of Birth:

Sex M F

SS#

Emergency Contact:

Relationship:

Home Phone: *Include area code* ( )

Cell Phone: *Include area code* ( )

If you are completing this form for another person, what is your relationship to that person?

Your Name

Relationship

Do you have any of the following diseases or problems: ***(Check DK if you Don't Know the answer to the question)***

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information

For the following questions, please mark (X) your responses to the following questions.

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply floridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY/WEEKLY/OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you clench or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:

What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information

Please mark (x) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name:

Phone: *Include area code* ( )

Address/City/State/Zip:

	Yes	No	DK
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

	Yes	No	DK
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and /or diet supplements:

____

____

____

____

Medical Information

Please mark (x) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question) Yes No DK

Do you wear contact lenses? ☐ ☐ ☐

Joint replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ ☐ ☐
Date:____________If yes, have you had any complications?____________

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? ☐ ☐ ☐

Since 2001,were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ ☐ ☐
Date Treatment began:

Yes No DK

Do you use controlled substances (drugs)? ☐ ☐ ☐

Do you use tobacco (smoking, snuff, chew, bidis)? ☐ ☐ ☐
If so, how interested are you in stopping?
(Circle one) VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? ☐ ☐ ☐
If yes, how much alcohol did you drink in the last 24 hours? ____________
If yes, how much do you typically drink in a week?____________

WOMEN ONLY Are you:
Pregnant? ☐ ☐ ☐
Number of weeks: ____________
Taking birth control pills or hormonal replacement? ☐ ☐ ☐
Nursing? ☐ ☐ ☐

Allergies- Are you allergic to or have you had a reaction to : Yes No DK
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics ____________	☐	☐	☐
Aspirin ____________	☐	☐	☐
Penicillin or other antibiotics ____________	☐	☐	☐
Barbiturates, sedatives, or sleeping pills ____________	☐	☐	☐
Sulfa drugs ____________	☐	☐	☐
Codeine or other narcotics ____________	☐	☐	☐
Metals ____________	☐	☐	☐
Latex (rubber) ____________	☐	☐	☐
Iodine ____________	☐	☐	☐
Hay fever/seasonal ____________	☐	☐	☐
Animals ____________	☐	☐	☐
Food ____________	☐	☐	☐
Other ____________	☐	☐	☐

Please mark (x) your response to indicate if you have or have not had any of the following disease or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: ____________			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic Lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: ____________			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: ____________			
Recurrent Infections	☐	☐	☐
Type of infection: ____________			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation: | Phone

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐
Please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate, I understand the importance of a truthful healthy history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/legal Guardian: | Date

FOR COMPLETION BY DENTIST

Comments:____
____
____
____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

' U k ' o u '

I ____ have received a copy of this office's Notice of Privacy Practices.

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For Office Use Only

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

Please check applicable box

- ☐ Individual refused to sign
- ☐ Communications barriers prevented obtaining an acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other, *please specify*:

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