FAMILY AND COSMETIC DENTISTRY

Patient Registration

Welcome to BrightWhites! We look forward to helping you maintain good oral health and meet your smile goals. Kindly, complete the form below so we can get started!

Today's Date: _____/_____/_____

Name: Mr. / Mrs. / Ms. / Dr. (Last)_____(First)_____(MI)_____

I prefer to be called _____ Male _____ Female _____ ¯ Single ⊓ Married

Birth Date _____/_____/_____ Age _____ SSN _____

Home Address _____ Apt /Condo # _____

City _____ State _____ Zip Code _____

Home Phone _____ Same as cell? Y / N _____

Work Phone _____Email Address _____

Employer _____ Occupation _____

Work Address _____

Best way / time to reach you _____ Whom may we thank for referring you? _____

Do you have dental insurance? Yes/No Name of Insurer_____

Why have you come to the dentist today? _____ Last Dental Visit _____

Name of Physician_____ Phone _____

DO YOU or HAVE YOU EVER HAD:	YES	NO		YES	NO
1. Anemia or Radiation Treatment			17. Hepatitis		
2. Artificial Bones, Joints, or Valves			18. High / Low Blood Pressure		
3. Arthritis			19. HIV Positive / AIDS		
4. Asthma			20. Hospitalized for any reason		
5. Blood Transfusion			21. Kidney Problems / Dialysis		
6. Cancer / Chemotherapy			22. Mitral Valve Prolapse		
7. Congenital Heart Defect			23. Osteoporosis		
8. Diabetes			24. Psychiatric Problems		
9. Difficulty Breathing			25. Rheumatic / Scarlett Fever		
10. Drug / Alcohol Abuse			26. Severe / Frequent Headaches		
11. Emphysema / Glaucoma			27. Shingles		
12. Epilepsy / Seizures / Fainting Spell			28. Sickle Cell Disease / Trait		
13. Fever Blisters / Herpes			29. Sinus Problems		
14. Heart Attack / Stroke			30. Tobacco Use		
15. Heart Murmur			31. Tuberculosis (TB)		
16. Heart Surgery / Pacemaker			32. Ulcerative Colitis / Crohn's Dz		
17. Hemophilia / Abnormal Bleeding			33. Venereal Disease / STD		

Please list any serious medical conditions you have ever had _____

_____

Are you currently taking prescription medications, vitamins, or supplements _____

_____

Are you allergic to any of the following? ☐ Aspirin ☐ Erythromycin ☐ Penicillin ☐ Tetracycline ☐ Aspirin ☐ Ibuprofen ☐Acetaminophen ☐ Codeine☐ Jewelry / Metals ☐ Dental Anesthetics ☐ Latex ☐ Other _____

⊓ Yes ∆ No Do you require antibiotics before dental treatment? ⊓ Yes ∆ No Are you currently in pain?

⊓ Yes ∆ No Have you ever had a serious / difficult problem associated with any previous dental work?

⊓ Yes ∆ No Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ/TMD)?

Do you like your Smile? ¯ Yes ∧ No Do your gums ever bleed? ¯ Yes ∧ No

I understand that the information that I have given today is correct to the best of my knowledge and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

FAMILY AND COSMETIC DENTISTRY

Office Policy & Financial Information

BrightWhites is committed to providing you with the best possible dental care. ***Payment for services is due at the time services are rendered,*** unless prior payment arrangements have been made and approved in writing. We gladly accept Visa, Mastercard, Discover, American Express, checks or cash. We also offer financing through Care Credit.
A charge will be made for failed appointments or those broken without 48 hours notice. Appointment time is reserved in advanced and with short or no notice, we do not have the opportunity to provide that time to another patient.
Returned checks are subjected to additional collection fees and interest rate of 1.5% per month. If an account becomes delinquent, the guarantor will be responsible for all legal fees incurred in collection of that account.

Insurance Policy
Your benefit plan is a contract between you, your employer, and the insurance company, and we are a party to that contract. We will advocate to help you obtain the maximum benefit provided by your plan and we are happy to assist you in understanding your specific plan. Not all services are covered in all contracts. Further, all policies have limitations and restrictions in order to keep the premium lower to employer or sponsor. However, this does not dictate what treatment to which you are entitled. If you have any questions about the information set above, please do not hesitate to ask.

- I understand that my insurance is an agreement between my insurance company and me. I also understand that I am financially responsible for my account, regardless of my insurance.
- I authorize BrightWhites to take any necessary diagnostic films, photos, or study models to properly enable and complete diagnostics and treatment.
- I further authorize BrightWhites to release any required information to outside health practitioners and for the purpose of processing insurance claims.
- ***I have read the above statements and fully understand and agree to these terms and conditions.***

BrightWhites will gladly provide assistance to all patients who may have inquiries about their dental insurance benefits, estimate of a proposed treatment plan, pending claims, eligibility for dental insurance coverage, and other insurance/billing questions. However, it is the patient's responsibility to be familiar with their own dental insurance plan. All insurance and financial concerns should be addressed and resolved before the scheduled treatment appointment with the doctor. We are not affiliated in any way with any medical or dental insurance plans, or flexible spending accounts. Your insurance company will be billed for applicable charges after today's service. Should there be any remaining balance after your insurance is charged, you will be responsible for paying these remaining charges. You may also be liable for any agency fees associated with collecting the balance of any remaining charges left due and unpaid after a 90-day period. By signing this form, you agree to this.

Broken Appointment / Cancellation Policy
It is important that you keep your appointment. Valuable time has been reserved for your care, and a missed appointment results in lost time that could have been used by another patient waiting to receive treatment. We require 48-hour advanced notice when cancelling an appointment that has been reserved for you. Please notify us promptly if you are running late.
There is a broken appointment fee of $75.00 for the first hour and $25.00 each half hour thereafter for which your appointment was scheduled. Depending on the nature of the cancellation, any combination of failing to give adequate cancellation notice or not showing for several appointments may result in dismissal from this practice.

Printed Name _____ Date _____

Signature _____

Acknowledgement of Receipt of Notices of Privacy Practices **You may refuse to sign this Acknowledgement*

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

Signature _____ Date _____