# Brighter Smiles Family Dentistry

## Welcome To Our Office!

Our team believes that our patients are the most important people in the world. We appreciate that you have chosen our team as your dental "family". It is our goal to provide you with the best dental care in a friendly and comfortable environment. We understand the importance of excellent dental care and the impact a confident smile can provide. Please inform us of any dental problems or concerns so we can better serve you. We will do our best to listen and provide you with warm, compassionate care.

Financial Policy: Please understand that payment of your bill is considered a part of your treatment. All payments are due at the time of service. For patients who carry dental insurance, we will help prepare your insurance forms or assist in making collections from insurance companies. However, we cannot render services on the assumption that our charges will be paid by your insurance company. You as the patient understand that all dental services furnished will be charged directly to the patient and that he or she is personally responsible for payment of all dental services not covered by your insurance company. Patients also acknowledge that all co-pays are estimated. Both co-pays and deductibles are due prior to treatment. If there is a remaining balance after your estimated co-pays and insurance payments, you will be responsible for the balance. We have made payments easier by offering 3, 6, 12, and 18 month interest free payment plans through Chase and Care Credit. Long term payment plans are also available.

Cancellation Policy: We understand that people have busy schedules and sometimes emergencies come up. If you are unable to make an appointment, please notify us at least 48 hours in advance. We have allotted a certain amount of time for your appointment and if you do not give us advance cancellation notice, it is difficult for us to schedule another patient. **A FEE OF $75 PER CANCELLED APPOINTMENT WITHOUT 48 HOUR NOTICE WILL BE CHARGED TO YOUR ACCOUNT.** We also reserve the right to drop a patient from our practice after 3 cancelled appointments in any 1 year period.

Due to clinical situations, a proposed treatment plan may change. You will be informed of any changes in treatment as they occur and you will be financially responsible for any changes. Thank you for understanding our financial policy.

I have read and fully understand all of the information above and agree to comply with all office policies.

Print:_____ X_____ Date:_____

Print — Signature of Patient or Responsible Party

**Thank you for choosing us, we know you have a choice!**

# PATIENT REGISTRATION FORM

First Name_____MI ___Last Name: _____Nick Name:_____

Date of Birth:_____ Age:_____SS#_____E-Mail:_____

Address:_____City:_____State:_____ Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Employer:_____Occupation:_____ Referred By:_____

Are you: Single_____ Married_____ Widowed_____ Divorced_____ Separated____

RESPONSIBLE PARTY (If self, skip to the next section)

Self___ Spouse____ Father____ Mother____ Other____ Home Phone_____

Name_____SS#_____Date of Birth_____

Address: _____City:_____State:_____ Zip:_____

Employer: _____Phone: _____

PRIMARY DENTAL INSURANCE

Employer: _____

Business Address:_____

Phone:_____ Plan:_____

Insurance Company: _____

Group Name:_____

Group#:_____

Identification #:_____

Primary Insured:_____

Relationship to Primary Insured:_____

SECONDARY DENTAL INSURANCE

Employer:_____

Business Address:_____

Phone: _____ Plan:_____

Insurance Company: _____

Group Name:_____

Group#: _____

Identification #:_____

Primary Insured:_____

Relationship to Primary Insured:_____

Purpose of this appointment_____

In case of emergency, who should we notify?_____

Relationship to you?_____Phone_____Cell_____

Comments_____

_____

Your Signature_____ Today's Date_____

Patient Name_____

**Dental History:**

Do you have a specific dental problem? Describe: _____

Do you have dental examinations on a routine basis? Last visit: _____

Would you describe your present dental health as good? _____

Do your gums ever bleed? _____

Do you brush and floss on a routine basis? _____

Do you feel nervous about having dental treatment? _____

Who referred you to our office? _____

**Medical History:**

Medical Doctor's name _____

Are you under a doctor's care now? Why? _____

Are you allergic to any medications or substance? What? _____

_____

Are you taking any medications now? What? _____

_____

Are you pregnant? _____

Please **CIRCLE** if you have had any of the following:

| | | | |
|---|---|---|---|
| AIDS | Chest Pain | Hepatitis A (infect.) | Psychiatric Care |
| Allergies | Congenital Heart Lesion | Hepatitis B (serum) | Radiation |
| Anemia | Diabetes | Herpes | Rheumatic Fever |
| Artificial Heart Valve | Drug Addiction | High Blood Pressure | Scarlet Fever |
| Artificial Joints | Epilepsy or Seizures | HIV | Tuberculosis |
| Asthma | Glaucoma | Kidney Trouble | Ulcers |
| Blood Disease | Heart Pacemaker | Liver Disease | Venereal Disease |
| Blood Transfusion | Heart Surgery | Low Blood Pressure | |
| Cancer | Heart Trouble | Lung Disease | |
| Chemotherapy | Hemophilia | Nervousness | |

Have you ever had any other serious illness not circled above? _____

_____

Patient Signature (Parent or Guardian)

**Pharmacy Information:**

_____

_____

_____

_____

# NEUROMUSCULAR QUESTIONNAIRE AND SMILE ASSESSMENT FORM

1. DO YOU HAVE HEADACHES?
Yes No
2. DO YOU HAVE JOINT PAIN?
Yes No
3. DO YOU HEAR NOISES IN THE JAW JOINT CLICKING OR SCRAPING?
Yes No
4. DO YOU HAVE EAR CONGESTION?
Yes No
5. DO YOU HAVE TINNITUS (RINGING IN THE EARS)?
Yes No
6. DO YOU HAVE PAIN IN THE NECK OR SHOULDERS?
Yes No
7. ARE YOUR TEETH SENSITIVE TO HOT COLD OR SWEETS?
Yes No
8. DO YOU HAVE DIFFICULTY IN CHEWING?
Yes No
9. DO YOU CLENCH OR GRIND YOUR TEETH DURING THE DAY OR NIGHT?
Yes No
10. DO YOU HAVE LIMITED OPENING OF THE JAW?
Yes No

11. I AM CONCERNED ABOUT THE APPEARANCE OF MY TEETH OR MY SMILE.
Yes No
12. I AM CONCERNED ABOUT THE WHITENESS/LACK OF WHITENESS OF ONE OR MORE OF MY TEETH.
Yes No
13. I AM CONCERNED ABOUT THE POSITION OR ANGLE OF ONE OR MORE OF MY TEETH.
Yes No
14. I AM CONCERNED ABOUT THE SHAPE OF ONE OR MORE OF MY TEETH.
Yes No
15. IN SOCIAL SITUATIONS, I AM SOMETIMES EMBARRASSED BY MY TEETH OR MY SMILE.
Yes No
16. THERE ARE SOME THINGS ABOUT MY TEETH THAT I WOULD LIKE TO CHANGE.
Yes No
17. I HAVE OLD FILLINGS OR PREVIOUS DENTAL TREATMENT THAT IS NO LONGER SATISFACTORY TO ME.
Yes No
18. I AM MISSING ONE OR MORE OF MY TEETH.
Yes No
19. I AM INTERESTED IN LEARNING MORE ABOUT ESTHETIC DENTISTRY.
Yes No

# PATIENT HIPAA AWARENESS

With my permission, Brighter Smiles Family Dentistry may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Brighter Smiles Family Dentistry Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Brighter Smiles Family Dentistry reserves the right to revise its Notice of Privacy Practices at anytime.
A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Brighter Smiles Family Dentistry may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Brighter Smiles Family Dentistry may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and or Confidential.

With my permission, the office of Brighter Smiles Family Dentistry may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Brighter Smiles Family Dentistry restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Brighter Smiles Family Dentistry to use and disclosure my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Name of Patient or Legal Guardian Date