Welcome

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available.

Patient Information

Name_____ Nickname _____
DOB _____ Age _____SS# _____
Home Phone_____ Cell Phone _____
Address _____City_____ Zip _____
How do you prefer to be contacted? Call Text E-Mail
Do you prefer appointments in the (circle all that apply): Morning Afternoon No Preference
How did you hear about our office? _____

SEX ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single ☐ Minor
E-mail _____Cell phone #2 _____
Employer_____ Employer Phone _____
Employer Address _____City _____Zip _____
Spouse _____Employer_____ Phone # _____
Please name your immediate family (children/last names) _____
Who may we thank for referring you? _____
Person to contact in case of emergency _____Phone #_____

Person Financially Responsible for Account

Name of person
Responsible for this account _____Relation to Patient _____
Address _____City_____ ZIP _____
Driver's License #_____DOB _____SS#_____
Employer_____ Work Phone _____
Currently a patient in our office? ☐ **YES** ☐ **NO** E-mail_____ Cell _____

Insurance Information

Name of Insured _____Relation to patient _____
DOB _____SS# _____Date Employed _____
Employer _____Work Phone _____
Employer Address _____City_____ ZIP _____
Insurance Co. _____Group #_____ Union/Local #_____
Address _____City_____ ZIP _____

Please indicate if you are covered by any additional insurance **YES** **NO**
Name of Insured _____Relation to patient _____
DOB _____SS# _____Date Employed _____
Insurance Co. _____Group #_____ Employer _____

Dental History

Reason for today's visit_____
Are you in pain? (If yes, describe)_____
Former Dentist _____Date of Last exam _____
Why are you with a new dentist today? _____
Any concerns you would like to share with us?_____

Please **(circle)** what applies to you:

Bad breath	YES	NO	Grinding teeth	YES	NO	Sensitivity when biting	YES	NO
Bleeding gums	YES	NO	Sensitivity to Cold	YES	NO	Do your gums bleed	YES	NO
Dental Treatment	YES	NO	Sensitivity to Sweets	YES	NO	Sensitivity to Hot	YES	NO
Broken fillings	YES	NO	Loose teeth	YES	NO	Clicking or popping jaw	YES	NO
Do you floss?	YES	NO	Sores/growths in your mouth	YES	NO	Food collection between teeth	YES	NO

How often do you brush? _____

Medical History

Physician's Name_____ Date of last Visit _____

Have you ever taken any "Fen-Phen"?	**YES**	**NO**	
Have you had any serious illness or operations?	**YES**	**NO**	If yes describe _____
Have you ever had a blood transfusion?	**YES**	**NO**	If yes, give dates_____
Have you had or have history of Endocardidis?	**YES**	**NO**	If yes, give dates _____
Do you use herbal remedies?	**YES**	**NO**	If yes describe _____
Do you take a daily (baby) aspirin?	**YES**	**NO**	
Are you taking any Bisphosphonates	**YES**	**NO**	
Medication for osteoporosis (Boneva/Fosomax)	**YES**	**NO**	

(**Women**)

Are you pregnant? **YES NO** Nursing? **YES NO** Taking birth control? **YES NO**

Please indicate yes or no if you have had or currently have any of the following:

Anemia	**YES**	**NO**	Congenital Heart Lesions	**YES**	**NO**	Hepatitis Type_____	**YES**	**NO**
Scarlet fever	**YES**	**NO**	Arthritis, Rheumatism	**YES**	**NO**	Cortisone treatments	**YES**	**NO**
Hernia Repair	**YES**	**NO**	Shortness of breath	**YES**	**NO**	Artificial heart valves	**YES**	**NO**
Cough, persistent	**YES**	**NO**	High blood pressure	**YES**	**NO**	Artificial joints, pins etc	**YES**	**NO**
Cough up blood	**YES**	**NO**	Skin rash	**YES**	**NO**	HIV/AIDS	**YES**	**NO**
Asthma	**YES**	**NO**	Diabetes	**YES**	**NO**	Stroke Date_____	**YES**	**NO**
Jaw Pain	**YES**	**NO**	Swelling of feet	**YES**	**NO**	Back problems	**YES**	**NO**
Epilepsy	**YES**	**NO**	Mental Disorders	**YES**	**NO**	Tuberculosis	**YES**	**NO**
Kidney Disease	**YES**	**NO**	Autism	**YES**	**NO**	Chemical Dependency	**YES**	**NO**
Thyroid Problems	**YES**	**NO**	Alzheimer's Disease	**YES**	**NO**	Pacemaker	**YES**	**NO**
Bleeding abnormally	**YES**	**NO**	Learning Disabilities	**YES**	**NO**	Periodontal Disease	**YES**	**NO**
Fainting	**YES**	**NO**	Heart Murmur	**YES**	**NO**	Osteoporosis	**YES**	**NO**
Liver Disease	**YES**	**NO**	Asperger Disease	**YES**	**NO**	Radiation Treatment	**YES**	**NO**
Tobacco Habit	**YES**	**NO**	Heart Problems	**YES**	**NO**	Ulcer	**YES**	**NO**
Blood Disease	**YES**	**NO**	Ulcer	**YES**	**NO**	Chemotherapy	**YES**	**NO**
Glaucoma	**YES**	**NO**	Respiratory Disease	**YES**	**NO**	Do you Pre-medicate	**YES**	**NO**
Mitral Valve Prolepse	**YES**	**NO**	Venereal Disease	**YES**	**NO**	Circulatory Problems	**YES**	**NO**
Tonsillitis	**YES**	**NO**	Hemophilia	**YES**	**NO**	Rheumatic Fever	**YES**	**NO**
Cancer Type_____	**YES**	**NO**	Lupus	**YES**	**NO**	Fibromyalgia	**YES**	**NO**
Headaches	**YES**	**NO**	Use of recreational drugs or alcohol	**YES**	**NO**			

List Medications you are currently taking and the correlation Diagnosis:

_____

_____

Allergies: **(Circle)**

Latex	Sulfa
Codeine	Iodine
Local Anesthetic	Penicillin
Other_____	**Other**_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Print name of Patient, Parent, or Guardian	Date	Signature of Patient, Parent, or Guardian	Date
_____	_____	_____	_____

For office use only Date reviewed_____ Dr Signature_____

Authorization and Release (Required)

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my Minor child, ever have a change in health.
I certify that I, and/or my dependent(s), Have insurance coverage with _____
Name of Insurance
and assign directly to *Bright Smile Dentistry* all insurance 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 authorize the use of my signature on all insurance submissions.
The above named dentist may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Date

Payment Options (Required)

To keep cost of Dentistry down, and to continue to provide quality care to our valued patients, we now only accept payment in full the day of treatment. We do accept insurance payments, we do process insurance claims as a courtesy to all our insurance patients, Please note insurance is never a guarantee of payment, we attempt to get all estimated portions and inform you prior to all dental treatment, we ask that you indicate form of payment desired for your dental portion.

We pride ourselves in always informing you of any cost you may incur before we begin treatment and to always receive your consent for all services rendered. There is a $25.00 charge for any returned checks. If a check is returned and not paid within 7 days of date, legal action may be taken for collection. You will assume any costs associated with collection of returned checks. **Initials _____**

Please (✓) the option(s) most convenient for you to settle your account, in full today.

- ❑ **Cash/ Check** (*in full day of treatment*)
- ❑ **Visa /MasterCard** (*in full day of treatment*)
- ❑ **Financing** *through* **Financing Options** *(on approved credit, see front office for application)*
  Interest free and low monthly payments available.

Privacy Practices

- ❑ **I hereby acknowledge I have been provide an opportunity to review a copy of this practices NOTICE OF PRIVACY PRACTICES.(HIPAA) I further understand that the practice will offer me updates to this NOPP should it be amended, modified or changes in any way. Initials _____**
- ❑ **I hereby acknowledge I have been provided an opportunity to review a copy of this practices Material Safety Data Sheet (MSDS) Acknowledgement. Initials _____**
- ❑ **I give Comfort Dental Consent to use my photos in official office use or for promotions online or for any advertisement. Initials _____**

Appointment Guideline

We request that all our patients give us a 24hr notice to cancel or reschedule their dental appointment. This will allow sufficient time to inform other patients of the availability in our Dr.'s schedule.
Thank you for your cooperation.
We understand emergencies please inform us as soon as you know you will need to change your scheduled appointment.

_____ _____
Signature *Date*

Patient Name:_____ Doctor:_____

1. **EXAMINATION AND X-RAYS** _____**(Initial)**
   I understand that the initial visit may require radiographs in order to complete the examination, diagnosis, and treatment plan.

2. **DRUGS, MEDICATION, AND SEDATION** _____**(Initial)**
   I have been informed and understand that antibiotic, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand that and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic medication and drugs that may have been given me in the office for my treatment. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

3. **CHANGES IN TREATMENT PLAN** _____**(Initial)**
   I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any or all changes and additions as necessary.

4. **TEMPOROMANDIBULAR JOINT DYSFUNCTIONS (TMJ)** _____**(Initial)**
   I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility.

5. **FILLINGS** _____**(Initial)**
   I understand that care must be exercised in chewing on filling during the first 24 hours to avoid breakage, and tooth sensitivity is common after-effect of a newly placed filling.

6. **REMOVAL OF TEETH (EXTRACTION)** _____**(Initial)**
   Alternative to removal has been explained to me (root canal therapy, crowns, periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth and any others necessary for the reasons in paragraph #3. I understand removing teeth does not always remove all infection if present and it may be necessary to have further treatment. I understand the risks involved is having teeth removed, some of which are pain, swelling, and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (parathesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

7. **CROWNS, BRIDGES, VENEERS AND BONDING** _____**(Initial)**
   I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realized that the final opportunity to make changes in my new crowns, bridge or cap (including shape, fit, size, placement, and color) will be done before cementation. It has been explained to me that, in very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.

8. **DENTURES – COMPLETE OR PARTIAL** _____**(Initial)**
   I realize that full or partial dentures are artificial, constructed of plastic, metal and or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not the initial denture fee.

9. **ENDODONTIC TREATMENT (ROOT CANAL)** _____**(Initial)**
   I realize there is no guarantee that root canal treatment will save my tooth and those complications can occur from the treatment and that occasionally metal objects are cemented in the tooth, or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

10. **PERIODONTAL TREATMENT** _____**(Initial)**
    I understand that I have a serious condition causing gum inflammation and/or bone loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery and/or extractions. I understand the success of a treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, following a healthy diet, avoid tobacco products and follow other recommendations.

CONSENT: *I understand that dentistry is not an exact science, therefore: reputable parishioners cannot properly guarantee results. I acknowledge that no guarantee or assurance as been made by anyone regarding the dental treatment which I have requested and authorize. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist other than the treating Dentist is responsible for my dental treatment.*

Signature: _____ Date: _____