Welcome

Thank you for selecting Brite Care Dental! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out the following forms completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

Personal Information

Date: ________________________________

Date of Birth: _______________________________

Social Security #: ____-____-____ Email: ____

Name: ____

Nickname (Optional): _________________________

( ) Male ( ) Female ( ) Minor ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated

Address: ____

City: _____________________________ State: ___________ Zip Code: ________________

Employer: ______________________________ Occupation: __________________________

Referred By: __________________________________

Home Phone: ____- ____-____ Cell Phone: ____- ____-___ Work Phone: ____- ____-____

Emergency Contact Name: _______________________________

Phone Number: ____- ____-____ Relationship to Patient: ___________________________

Dental History

1. Reason for visit: ____
2. When was your last dental visit? ____
3. How often do you brush your teeth? ____
4. What texture brush do you use? ( ) Soft ( ) Medium ( ) Hard

5. Do your gums bleed while brushing?	Y	N	13. Have you had any head/neck/ jaw injuries?	Y	N
6. Do your gums bleed when flossing?	Y	N	14. Do you have frequent headaches?	Y	N
7. Do you feel pain while brushing or flossing?	Y	N	15. Do you clench or grind your teeth while awake or sleep?	Y	N
8. Are your teeth sensitive to hot, cold, sweet or sour foods/liquids?	Y	N	16. Do you bite your lips or cheeks frequently?	Y	N
9. Have you noticed any loosening of your teeth?	Y	N	17. Have you ever had:		
			a. Orthodontic treatment (braces)?	Y	N
10. Does your food tend to become caught between your teeth?	Y	N	b. Oral Surgery?	Y	N
			c. Gum Treatment?	Y	N
11. Do you have any sores or lumps in or near your mouth?	Y	N	d. Your teeth ground or the bite adjusted?	Y	N
12. Have you ever experienced any of the following problems in your jaw?			e. Worn a bite plane or other appliance?	Y	N
a. Clicking?	Y	N	18. Are you satisfied with the appearance of your teeth?	Y	N
b. Pain (joint, ear, side of face)?	Y	N			
c. Difficulty in opening or closing?	Y	N	19. Have you ever had an upsetting experience in the dental office?	Y	N
d. Difficulty chewing?	Y	N			

Medical History

Physician: ____ Date of Last Visit: __________________

Address: ____ Phone: ____-____-____

Please circle Yes or No (If Yes, please explain)

Y N Are you taking any medication? ____

Y N Are you allergic to any medication? ____

Y N Do you have a history of a major illness? ____

Y N Have you had any operations? ____

Y N Have you ever been involved in a serious accident? ________________________________

Y N Have you seen a physician in the last 12 months? Why? ____________________________

Circle any of the medical conditions below that you have had or currently have:

Abnormal Bleeding/ Hemophilia	Diabetes	Hepatitis/ Liver Problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/ Chemotherapy
Asthma or Hay fever	Gastrointestinal Disorder	HIV/Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney Problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of?

____

Dental History

General Dentist: ____ Date of Last Visit: __________________

What concerns you most about your teeth? ____

Y N Are you presently in any dental pain? ____

Y N Have you ever lost or chipped any teeth? ______________________________________

Y N Have there been any injuries to face, mouth, or teeth? ______________________________

Y N Is any part of your mouth sensitive to pressure? Where? ____________________________

Y N Do you have any type of thumb or tongue habit? ___________________________________

Y N Are you a mouth breather? ____

Y N Have you ever seen an orthodontist? If so, who and when? __________________________

Y N Has anyone in your family received orthodontic treatment? ________________________
How did they feel about the result? ____

Y N Do your teeth or jaws ever feel uncomfortable when you wake in the morning?

Y N Do you have tension headaches? ____

Y N Have you ever experienced chronic ringing in your ears? _______________________

Y N If the patient is under 16, height of parents? Mom _____ Dad _____

Y N Are you aware that some appointments will be during work/school hours?

Female Patients ONLY:

Y N Are you pregnant? ____

Y N Has menstruation started? ____

Signature: _______________________________________ Date: ______________________

Dental Insurance Information

Primary Insurance	Additional Insurance
Name of Insured: ____________________________	Name of Insured: ____________________________
Relationship to patient: _______________________	Relationship to patient: _______________________
Insured's Birthdate: __________________________	Insured's Birthdate: __________________________
SSN #: ____-____-____	SSN #: ____-____-____
Employer: __________________________________	Employer: __________________________________
Date Employed: _____________________________	Date Employed: _____________________________
Insurance Company: __________________________	Insurance Company: __________________________
Group #: ___________________________________	Group #: ___________________________________

Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay les that the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf of my dependents.

Signature: ____ Date: ______________________

Informed Consent for Dental Treatment: Generic Form

The dental treatment that is necessary to treat my existing oral condition(s) has been explained to me and I have had the opportunity to have my questions answered satisfactorily.

I understand that dentistry is not an exact science and outcomes may vary.

I authorize Dr. Momodu and/or such associates and assistants as may be necessary to perform the following procedures **as needed but not limited to**:

Comprehensive Oral Examination, Dental Restorations, and/or extractions of non-restorable infected teeth.

The possible administration of any anesthetic or any medication or pharmaceutical agents that may be necessary.

I voluntarily assume any or all possible risks that may be associated with any of these procedures. I understand it is my responsibility to diligently follow the instructions given to me in regard to my treatment.

Patient Signature: ____ Date: ____________________

Doctor Signature: ____ Date: _____________________

No Show/Cancellation Policy:
Our office will charge a fee of $25.00 to your account for all "no-shows" or cancellations in which the patient does not give our office at least 48 hours' notice. The office requests that if you are unable to make your scheduled appointment, you call to re-schedule your appointment. If it is after or before regular business hours please leave a message and we will return your call.

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Initials

Financial Agreement:
All co-pays are to be paid at the time of service. If you are unable to fulfill your financial responsibility we do reserve the right not to render services at the scheduled appointment. Our office accepts cash, personal checks, money orders, MasterCard and Visa. Outside financing is available through Care Credit upon request and approval. Our office does not accept payment plans and you may be subject to a billing fee if a statement is sent. Returned checks will be subject to a $35.00 returned check fee.

Assignment of Benefits:
Our office will accept assignment of benefits from your insurance company with the provisions listed below. It is important to understand that the agreement regarding your dental benefits is between you, your employer and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims:

- We will bill your insurance company as a courtesy with your consent assigned below.
- We require you pay the estimated portion not covered by your insurance company at the time we provide service to you.
- The portion that we estimate, is only an estimate which could result in an additional amount due after benefits have been paid to our office.
- Insurance is ordinarily received within 30-45 days from the time of billing. If your insurance company has not made payment to our office within 45 days, you will be responsible for the entire balance at that time. At that point you will be responsible for seeking reimbursement from your insurance company at that time.
- We do not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- We will not enter into a dispute with your insurance company over any claim, although we will provide the necessary documentation if your insurance company requests to sort out any confusion or questions that may arise. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I have read and accept the terms and conditions of this assignment of benefits agreement. I authorize my insurance company to pay my dental benefits directly to Brite Care Dental.

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Initials

HIPAA/Patient Privacy Act:
The Health Insurance Portability and Accountability Act requires that his office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future. To comply with one of HIPAA's requirements, we are offering to give you a copy of our Notice of Privacy Practices. This policy contains information that HIPAA requires us to disclose regarding our privacy practices.
We are also required to obtain your written consent and acknowledgement prior to disclosing any of your information except for our disclosures in connection with: defense to a claim challenging our professional competence; a review of entity's functions; a claim for payment of fees; a third party payer's examination of our records; court order as a part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation. It may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to consult with another dentist or health care professional, provide material to a laboratory or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

_______________________________________ ____________________
Patient Signature (Parent/Guardian if under 18) Date