BrightSmiles
Brilliant dental care

PATIENT REGISTRATION

Patient Information

Patient Name: ______________________________ Birth Date: ____________ Social Security #: ______________

How did you hear about our office? ______________________________

If referred by a friend/family please provide their name. **Who can we thank?** ______________________________

Address: ______________________________

____

Contact #'s: Home: ____________________ Work: ____________________ Cell: ____________________

E-Mail Address: ______________________________

How would you like your appointment reminders? ○ Phone Call ○ Email ○ Text

Responsible Party (if someone other than the patient)

Name: ______________________________ Birth Date: ____________ Social Security #: ______________

Address: ______________________________

____

Phone #'s: Home: ____________________ Work: ____________________ Cell: ____________________

Primary Insurance Information

Name of Insured: ______________________________ Birth Date: ____________

Social Security #: ____________________ Member ID: ____________________ Group#: ____________________

Insured's Address: ______________________________

____

Insurance Plan Name: ______________________________

Insured's Employer: ______________________________

Relationship to Patient: ○ Self ○ Spouse ○ Father ○ Mother ○ Other

Authorization

I authorize my insurance company to pay to Idaho Center Dental Care or its doctors all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure payment of benefits. I understand that Idaho Center Dental Care cannot render services on the assumption that any of the charges will be paid by an insurance company. **I understand that I am financially responsible for all charges whether paid by my insurance or not. I understand that if I do not pay my bill, collection action will be taken and I will be responsible for paying any collection and attorney fees. There will be a $50.00 charge for any missed appointments unless 24 hours notice is given prior to missing your appointment.**

Patient's signature: ______________________________ Date: ____________________

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Patient Name: ________________________________ Date of Birth: ____________

DENTAL HISTORY

Why have you come to the dentist today? ________________________________

When did you last visit a dentist? ____________________ Was the treatment completed? ◯Yes ◯No

How long since your last dental cleaning? ________________ Have you received periodontal/gum treatment? ◯Yes ◯No

Have you ever had prolonged bleeding after an extraction? ◯Yes ◯No

Have you been diagnosed with or concerned you have sleep apnea? ◯Yes ◯No

Do you grind your teeth or have pain in the jaw joint? ◯Yes ◯No

Is there anything about your smile you have concerns with? ◯Yes ◯No

Have you had any problems with past dental treatment? ◯Yes ◯No

MEDICAL HISTORY

Are you under a Doctor's care at this time? ◯Yes ◯No If yes, please specify Dr. Name: ____________________

Are you allergic to latex, penicillin, local anesthetics, or any other drugs or medicine? ____________________

Are you taking any medications at this time, including birth control? ◯Yes ◯No If yes, please specify:

____

____

____

(Woman) Are you pregnant at this time? ◯Yes ◯No If yes, please specify how many months: ________________

Have you been diagnosed with cancer? ◯Yes ◯No If so have you been treated? ____________________

Have your taken Bisphosphate for bone density, such as Fosamax, Boniva, Aredia, Actonel, Reclast, Zometa? ____________

Do you have, or have you had, any of the following?

☐ ARTIFICIAL HEART VALVE	☐ FAINTING	☐ PACEMAKER
☐ AIDS/HIV+	☐ GLAUCOMA	☐ PHEN-FEN
☐ ANEMIA	☐ HEART ATTACK	☐ PSYCHIATRIC CARE
☐ ANGINA	☐ HEART SURGERY	☐ RHEUMATIC FEVER
☐ ARTHRITIS	☐ HEART MURMUR	☐ SINUS TROUBLE
☐ ASTHMA	☐ HEART PROBLEMS	☐ SLEEP APNEA
☐ BLEEDING PROBLEMS	☐ HEPATITIS	☐ SMOKING TOBACCO
☐ CANCER	☐ HIGH BL. PRESSURE	☐ STROKE
☐ CHEMO/RAD THERAPY	☐ JAUNDICE	☐ THYROID PROBLEMS
☐ COSMETIC SURGERY	☐ JOINT REPLACEMENT	☐ TMD OR TMJ
☐ DIABETES	☐ KIDNEY DISEASE	☐ TUBERCULOSIS
☐ DIZZY SPELLS	☐ LATEX ALLERGY	☐ VENEREAL DISEASE
☐ DRUG ADDICTION	☐ LIVER PROBLEMS	☐ LUNG DISEASE
☐ EMPHYSEMA	☐ LOW BLOOD PRESSURE	☐ EPILEPSY

Are there any other health problems of which we should be advised? Please specify: ____________________

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature: ________________________________ Date: ______________

(Parent if Patient is a minor)

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Financial Policy

PLEASE READ CAREFULLY

We are committed in helping all of our patients receive the needed treatment to achieve and maintain optimal dental health. We offer the following financial agreement and payment options.

All estimated fees are due at the time of service

For our patients with dental insurance:

We will gladly process your primary and secondary insurance claims with the following understanding:

Initial _____ Dental Insurance is an agreement between you and your insurance company; therefore we can only estimate your dental benefits. This estimate is not a guarantee of payment by your insurance company.

Initial _____ You are responsible for any charges your insurance company does not pay.

Initial _____ Your out of pocket portion & deductibles are due at time of service. Insurance payments not paid after 60 days will become your complete responsibility.

For all our patients:

Initial _____ Returned checks are subject to a $25 collection fee.

Initial _____ Broken appointments and appointments cancelled without a 24 hour notice are subject to a $50 fee.

Initial _____ Any balance remaining in our office over 60 days will be responsible for a one-time $20 fee from an outside agency.

Financing Options:

We also offer financing options with no interest payments up to 12 months on approved credit with Care Credit

We accept all major credit cards.

______________________________ ______________________________ ________________

Print Name Signature Date

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NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ____, have read or been given an opportunity to read Bright Smiles Notice of Privacy Practices.

Please check one of the following:

- ☐ **I have retained a written copy of the notice of privacy practices.**
- ☐ **I have chosen NOT to retain a written copy of the notice of privacy practices.**

____ _______________
Please Print Patient's Name Date

____
Signature of Patient

In the event this request is made by the individual's personal representative:

____ _______________
Please Print Representatives Name Date

____
Signature of Representative

____
Relationship of Representative to the patient

For Office Use Only

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

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the acknowledgement**
- ☐ **An emergency situation prevented us from obtaining acknowledgement**
- ☐ **Other (Please Specify): _______________________________________**

____
____

____ _______________
Privacy Officer's Signature Date