Welcome to our Practice

EBRIGHT & SMART FAMILY DENTISTRY

Please take a few minutes to answer the following questions so we can help you with your dental needs.

PATIENT INFORMATION DATE_____

NAME_____DATE OF BIRTH_____

SOC. SEC. #_____ DRIVER'S LIC#_____

HOME PHONE_____CELL PHONE_____

HOME ADDRESS_____

EMAIL ADDRESS_____

EMPLOYER_____ WORK PHONE_____

BUSINESS ADDRESS_____OCCUPATION_____

Spouse_____ Number of children in family_____

Names of children_____

Who should we thank for referring you?_____

Who should we contact in case of an emergency?_____

DENTAL INSURANCE INFORMATION

SUBSCRIBER'S NAME_____ S.S.#/ID#_____

INSURANCE NAME & ADDRESS_____

EMPLOYER_____GROUP #_____

DOES THIS PLAN COVER ALL FAMILY MEMBERS?_____YES_____NO

ADDITIONAL INSURANCE INFORMATION

SUBSCRIBERS NAME_____

DOB:_____S.S.#/ID#_____

INSURANCE NAME & ADDRESS_____

EMPLOYER_____GROUP #_____

DOES THIS PLAN COVER ALL FAMILY MEMBERS?_____YES _____NO

ASSIGNMENT OF BENEFITS

I AUTHORIZE PAYMENT OF DENTAL BENEFITS TO MYSELF OR THE NAMED PROVIDER FOR PROFESSIONAL SERVICES RENDERED.

Signed_____ Date_____

RELEASE OF INFORMATION

I AUTHORIZE THE RELEASE OF ANY DENTAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

Signed_____Date_____

About financial arrangements and dental insurance

We are committed to providing you with the best possible care. If you have dental insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard, Visa, Discover and Care Credit. **As a courtesy to our patients we will be happy to process your insurance information or help you process the information for your reimbursement, however, ALL insurance information must be provided.**

Returned checks will be subject to an additional collection fee of $20. Charges may also be made for "NO SHOW" appointments.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

- Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
- Our fees are generally considered to fall within the acceptable range by most companies and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50 % or 80%) of "U.C.R" which is defined as usual, customary and reasonable fees for this region. Thus, our fees are considered usual, customary and reasonable by most companies.

- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as dental providers, our relationship is with you, not your insurance company. **While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.** We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask. We are here to help you.

Who is financially responsible for this bill?_____

Payment for today's visit will be by CASH_____ CHECK_____

CREDIT CARD_____ Exp._____

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on these forms and have completed the answers. I certify this information to be true and correct to the best of my knowledge.

NAME_____ **(print)** DATE_____

SIGNATURE_____

MEDICAL HISTORY

NAME_____ DATE_____

WHO IS YOUR PHYSICIAN?_____

PHYSICIAN'S
ADDRESS_____

WHEN WAS YOUR LAST PHYSICAL EXAM?_____

ARE YOU BEING TREATED FOR ANYTHING NOW?_____

HAVE YOU HAD ANY RECENT SURGERY ?_____

DO YOU HAVE ANY ARTIFICIAL HIPS, KNEES, SHOULDERS, HEART VALVES OR OTHER? IF YES, WHAT?_____

HAVE YOU BEEN TOLD YOU NEED TO PREMEDICATE BEFORE DENTAL TREATMENT BY YOUR PHYSICIAN? _____

DO YOU OR DID YOU EVER HAVE:

___kidney disease	___high blood pressure	___AIDS or HIV
___high cholesterol	___tuberculosis	___diabetes
___heart trouble	___asthma	___seizure disorders
___liver disease	___anemia	___hepatitis
___thyroid problems	___rheumatic fever	___venereal disease

_____other

Blood pressure reading_____

Have you ever been treated with radiation?_____

Are you allergic to any medications? If so what:_____
___Latex
___other allergies?

Are you pregnant?_____ If so, due date?_____

Are you taking any medications? If so,
what?_____

Are you subject to prolonged bleeding?_____

MEDICAL HISTORY CONTINUED

Are you high strung?_____

Has your diet ever been evaluated?_____

Do you have trouble sleeping?_____

Do you have problems with your digestion?_____

Do you smoke or chew tobacco? If so, what and how much per day?_____

DENTAL HEALTH HISTORY

When was your last dental exam?_____

What concerns you most about your dental history?_____

Do you have pain in any part of your mouth or in any tooth :

While biting or chewing?_____
With hot food or drinks?_____
With cold foods or drinks?_____
With sweets?_____

Does food catch between your teeth? Where?_____

Do your gums bleed or feel irritated or sore?_____

Do you clench or grind your teeth?_____

How often do you brush your teeth?_____

How often do you floss your teeth?_____

Are you happy with your teeth?_____

Do you have all of your teeth other than wisdom teeth?_____

Do you want to keep your teeth for as long as possible?_____

How often do you have your teeth cleaned?_____

Have you ever had gum surgery?_____

Signature_____Date_____

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EBRIGHT & SMART

FAMILY DENTISTRY

Alyssa Ebright DMD
Trevor Smart DMD

Name: _____ Date of Birth: _____

Address: _____ Phone number: (home) _____

_____ (cell) _____

Email Address: _____

Please fill out questionnaire completely for yourself (patient) or your dependent (child).

Do you have a fever or have you felt hot or feverish recently (14-21 days)?	Yes No
Are you having shortness of breath or other difficulties breathing?	Yes No
Do you have a cough?	Yes No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	Yes No
Have you experienced recent loss of taste or smell?	Yes No
Are you in contact with any confirmed or suspected COVID-19 positive patients?	Yes No
Have you traveled outside of New England within the last 14 days?	Yes No

Temperature: Date:

Pulse Oxidation:

*According to the CDC, ADA and NH Dental Board, a temperature of 100.4 °F and above is a risk factor for potential COVID-19 infection. Patients with an elevated temperature or symptoms of COVID-19 should be instructed to contact their primary care provider and re-scheduled for their dental procedure.